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JANUARY 1990

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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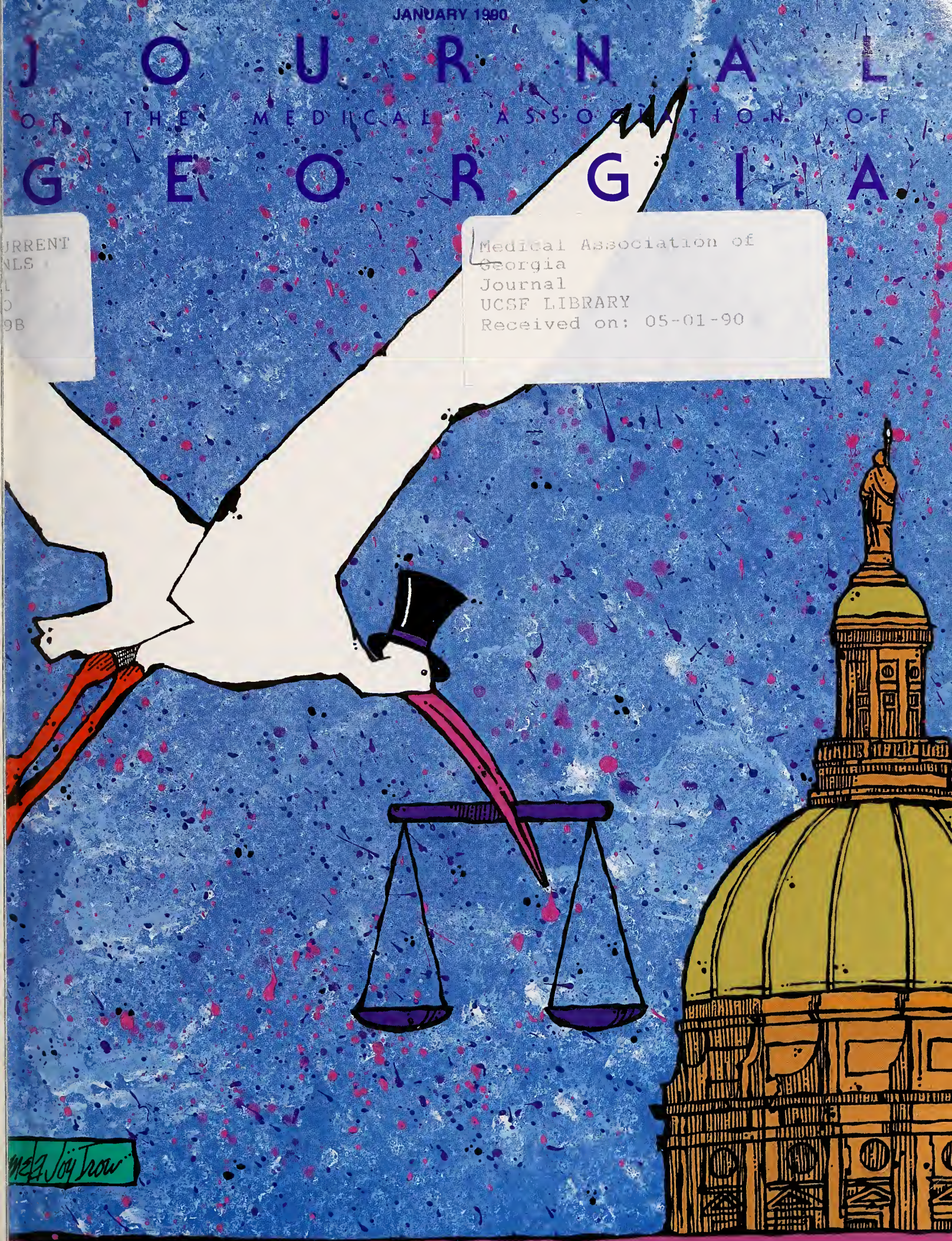

Legislating Abortion Rights "With Justice for All"

MRI UPDATE

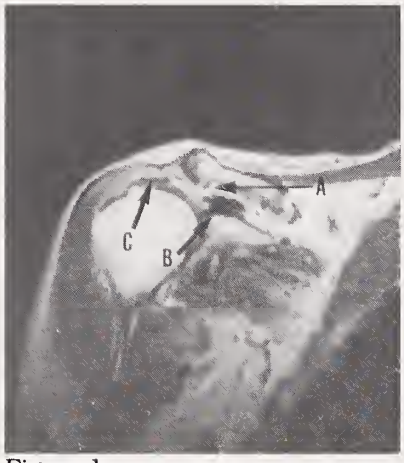

Figure 1

Figure 2

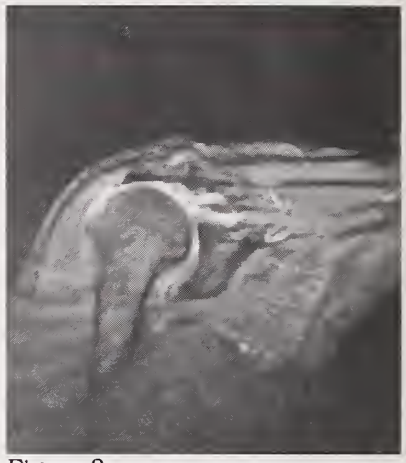
Figure 3

CLINICAL INFORMATION: This is a 69-year-old male who is unable to abduct his right arm and who has difficulty extending his arm. This is associated with right shoulder pain.

FINDINGS: Figure 1 is a proton density image in the coronal plane of the right shoulder. There is degenerative hypertrophy of the right acromioclavicular joint with a prominent inferior projecting osteophyte (A). A roughly linear area of low signal intensity inferior to the right distal clavicle represents the medial aspect of the rotator cuff (labeled B). A thin linear structure of low signal intensity superior to the right humeral head (labeled C) represents the lateral portion of the rotator cuff. Figure 2 is a T2-weighted image again demonstrating the inferior projecting osteophyte from the acromioclavicular joint (A) and the components of the torn rotator cuff (labeled B and C) as previously described. Increased signal intensity material between the torn portions of the rotator cuff represents joint fluid lying both within the joint space and in the subacromial bursa. Image #3 is a partial flip angle image which is sensitive for T2-weighting. This exhibits increased signal intensity in the immediate region of the rotator cuff tear as well as extending lateral over the right humeral head. The level of this slice is slightly anterior to figures 1 and 2 and the increased signal intensity material represents joint fluid extending over the right humeral head into the subdeltoid bursa.

The MR images demonstrate complete disruption of the rotator cuff which may be due to an acute injury or possibly due to chronic entrapment of the rotator cuff by the degenerated right acromioclavicular joint.

COMMENT: MR imaging is the only modality capable of directly visualizing and differentiating the various soft tissue components of the musculoskeletal system. Only CT arthrography approaches this degree of accuracy in the detection of rotator cuff tears, however CT arthrography like its cousin, routine shoulder arthrography, is invasive and requires injection of contrast into the shoulder joint. MR is the imaging modality of choice in the initial evaluation of soft tissue injuries of the shoulder joint with routine or CT arthrography reserved for those patients on whom the MR study was indeterminate.

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THE COVER

Our cover this month introduces the topic of abortion, various political and medical aspects of which are discussed in the Editor's Corner (p. 17), one editorial (p. 21), two articles (p. 29 and p. 31), and the Legal Section (p. 53).

Cover design by Pamela Joy Trow, of the Advertising Studio, Atlanta.

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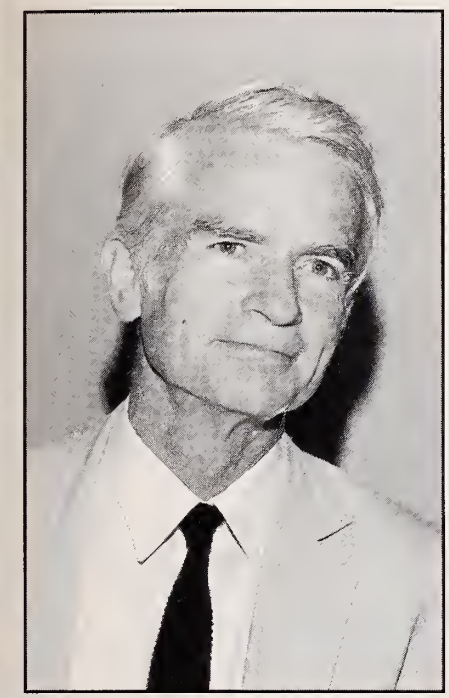

Joe L. Nettles, M.D.

MAG Leadership Conference

AFTER SEVERAL outstanding Leadership Conferences over the past few years, I thought it might be wise to pause, reflect, and skip this year. When I voiced that opinion to some of my colleagues, I was met with surprise and disappointment. I was reminded that we face more pressing issues than ever before, and have more new members who are anxious to play an active part in shaping the future of America's medicine.

So I quickly reconsidered, and with the aid of the MAG staff, a terrific program has been arranged. It will be February 3 and 4 at the Westin Lenox in Atlanta — and will be at the height of our legislative session. One feature of this year's program will be a discussion of medical issues with our gubernatorial candidates. We will also hear from other authorities on the more pressing medical problems and challenges that we are now facing.

This conference should better enable us to defend our traditional values and continue to provide quality medical care. So put February 3 and 4 on your calendar, and I will see you in Atlanta for our Leadership Conference.

And while you are at it, plan a visit to the Capitol to let your legislators know how you feel about the medical issues of the day. Even though we develop our best legislative rapport at home, our legislators are impressed to see that we are aware of what is going on and that we expect their support.

Joe Nettles

NEW MEMBERS

Erratum:
In the December 1989, Journal, **Robert D. Webb, M.D.,** *an ophthalmologist, was incorrectly identified as being a new member with the Georgia Medical Society. He is, instead, with the Thomas Area Medical Society. We apologize for this error.*

Barylska, Barbara W., Pediatrics — MAA — (Active N2) 2965 Johnson Ferry Rd., Marietta 30062

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PERSONALS

Georgia Medical Society

Robert F. Long, Jr., M.D., a radiologist from Savannah, has been named as a fellow of the American College of Radiology.

Medical Association of Atlanta

A Georgia physician who is one of the oldest practicing physicians in the country has been awarded the Atlanta Gas Light Company's 1989 Shining Light Award for her service to others.

The recipient is **Leila Daughtry-Denmark, M.D.,** 91, a pediatrician who has volunteered more than 60 years in caring for Atlanta's underprivileged children.

A native of Bulloch County, Dr. Daughtry-Denmark received her medical degree from the Medical College of Georgia in Augusta. She also holds an honorary Doctor of Humanities degree from Tift College and has received the Distinguished Alumna award from Tift, the Medical College of Georgia, Mercer University, and Georgia Southern College.

Her office is located in a 125-year-old farmhouse near Alpharetta. She has been credited with helping to develop a whooping cough vaccine and, in 1971, published a book entitled "Every Child Should Have a Chance."

Dr. Daughtry-Denmark was honored with a gas streetlight placed in the garden at Henrietta Hospital for Children in Atlanta where she began her career in 1928.

She was also recently honored in a featured article in the October 15, 1980, issue of *Parade* magazine. Contact the *Journal* office if you would like a copy of that article.

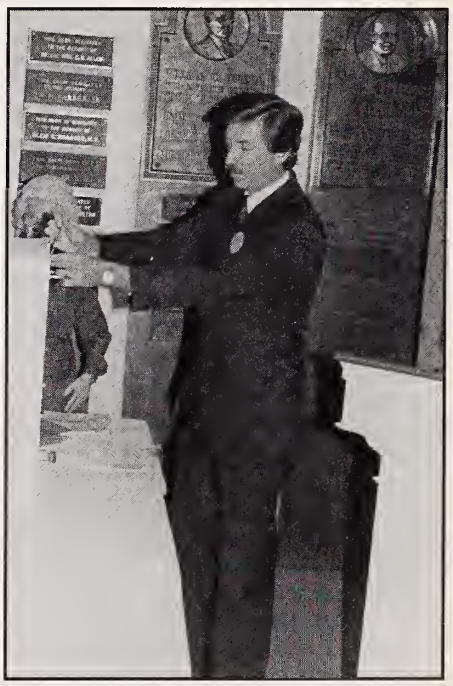
Whitfield-Murray CMS

William L. Barnwell, M.D., a Dalton ophthalmologist, has been elected president of the medical staff of Hamilton Medical Center for a 1-year term. *Luis Viamonte, M.D.,* a pediatrician, was elected vice president, and **John D. Richmond, M.D.,** who specializes in internal medicine and nephrology, was elected secretary.

Wilkes

M. Charles Adair, M.D., of Washington-Wilkes, has been recognized for his more than 35 years of continued membership in the American Academy of Family Physicians. Long-term members of the AAFP were honored at the opening ceremonies of the organization's 41st Annual Convention and Scientific Assembly in Los Angeles last September.

OTHER NEWS



Jim Lowry, Administrator of Colquitt Regional Medical Center, seals 50th anniversary time capsule containing the August, 1987, issue of the MAG Journal *which was devoted to hospitals. The capsule is to be opened in 2039 at the hospital's 100th anniversary. Mrs. Nora Manning, former hospital administrator, is in the background.*

MAG *Journal* in Time Capsule

As part of its 50th anniversary of continuous care to south

Georgia, the Colquitt Regional Medical Center in Moultrie installed a time capsule in the lobby of the hospital on October 23, 1989. Among the many items in the capsule was the August, 1987, issue of the *Journal of the MAG,* which focused on hospitals. In that special issue were many comments by physician and hospital leaders from around the state about the future of health care delivery and where we are headed. The capsule will be opened in 2039. Who among you will be there and remember this news item in the January, 1990, *Journal?*

DEATHS

William E. Gray, M.D., of Fairburn, owner and medical director of the Touchstone Clinic in College Park, died of a heart attack while seeing his patients at South Fulton Hospital. He was 63.

Dr. Gray, a family physicians and an addictionologist, established Touchstone Clinic in 1987. He previously was medical director of Willingway Hospital in Statesboro. He also had practiced medicine in California and Nevada.

Dr. Gray was born in Swainesboro. He attended Emory at Oxford and received a B.S. degree from the University of Miami School of Medicine. He was an Army Air Corps veteran of World War II.

Dr. Gray was actively involved in his community and in organized medicine.

QUOTES

Although hard to define, loyalty is easy to detect. Let a worker be ever so brilliant, ever so brainy, ever so ambitious, if his employers know he is not loyal through and through, they will not for a moment consider promoting him to a position of great trust and responsibility, for disloyalty breeds distrust.

B.C. FORBES

If other people are going to talk, conversation becomes impossible.

JAMES MCNEILL WHISTLER

Much meat, much malady.

THOMAS FULLER: *Gnomologia, 1732*

Love is like an hourglass, with the heart filling up as the brain empties.

JULES RENARD

Men who pass most comfortably through the world are those who possess good digestions and hard hearts.

HARRIET MARTINEAU

Luck is not something you can mention in the presence of self-made men.

E.B. WHITE

Who shall doubt "the secret hid
Under Egypt's pyramid"
Was that the contractor did
Cheops out of several millions?

RUDYARD KIPLING:
A General Summary, 1886

Can it be true, what is so constantly affirmed, that there is no sex in souls? — I doubt it, I doubt it exceedingly.

S.T. COLERIDGE
Table-Talk, June 24, 1827

To be seventy years young is sometimes far more cheerful and hopeful than to be forty years old.

O.W. HOLMES:
Letter to Julia Ward Howe on her seventieth birthday, May 27, 1889.

Patience is the best medicine.

JOHN FLORIO:
First Fruits, 1578

Apollo was held the god of physic, and sender of diseases. Both were originally the same trade, and still continue.

JONATHAN SWIFT:
Thoughts on Various subjects, 1706

Physic, for the most part, is nothing else but the substitute of exercise or temperance.

JOSEPH ADDISON:
The Spectator, Oct. 13, 1711

Love at first sight is only realizing an imagination that has always haunted us; or meeting with a face, or figure, or cast of expression in perfection that we have seen and admired in a less degree or in less favorable circumstances a hundred times before.

WILLIAM HAZLITT:
The Prose Album, 1829

Be what nature intended you for, and you will succeed; be anything else and you will be ten thousand times worse than nothing.

SYDNEY SMITH

I Resolve

To strive to contribute something to the world, its work and the people in it.
To spend and be spent in worthy service.
To adhere, the best I can, to the Golden Rule.
To philosophize more, recalling always, when things go awry, "This, too, will pass."
To try always to see viewpoints other than my own.
To make humility and simplicity so much a part of myself that I shall become as a child, as one of those of whom the Master declared, "For of such is the kingdom of heaven."

B.C. FORBES

It's just as unpleasant to get more than you bargain for as to get less.

GEORGE BERNARD SHAW

CALENDAR

JANUARY

8-12 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-13 — *Atlanta:* **Medical Management of Industrial Injuries in the Poultry Industry.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19-20 — *Atlanta:* **Retina-Vitreous Seminar.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-Feb. 2 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

FEBRUARY

2-3 — *Atlanta:* **27th Annual Emory-Grady Alumni Postgraduate Conference: Ophthalmology 1990.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-10 — *Park City, Utah:* **Acute Illness and Injuries.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

5-9 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10 — *Atlanta:* **Ethical Decision Making in Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-17 — *Breckenridge, CO:* **New Horizons in Anesthesiology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19-23 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-24 — *Augusta:* **Flexible Fiberoptic Sigmoidoscopy.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

MARCH

3-10 — *Steamboat Springs, CO:* **15th Annual Snow Job in Gynecology and Obstetrics.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-9 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-10 — *Augusta:* **25th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967

9-10 — *Augusta:* **Ophthalmology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

16 — *Macon:* **Cancer Management Update 1990.** AMA Category 1 credits and AAFP prescribed credits. Contact Robert Fore, Ed.D., Medical Center of Central Georgia, 777 Hemlock Street, Macon 31201. PH: 912/744-1634.

23 — *Atlanta:* **Perspective in Parenteral/Enteral Nutrition — 12th Annual Metabolic Support Service Seminar.** Category 1 credit. Contact Jean Robinson, Pharm.D., Metabolic Support Service, Georgia Baptist Medical Center, 300 Boulevard, Box 235, Atlanta 30312. PH: 404/653-4499.

26-30 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-30 — *Atlanta:* **The Cardiac Patient.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-31 — *Hilton Head Island, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

30-31 — *Atlanta:* **Expert Testimony.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

31-April 1 — *Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

MAG LEADERSHIP CONFERENCE

February 3-4, 1990
Westin Lenox Hotel
Atlanta

To register for our Annual Leadership Conference (including your choice of Sunday Seminars), please complete this Registration Form and return it with your check.

Name (please print) _____

Office Address _____

City _____ Zip _____ Office Phone _____

Registration Fees (please check):

LEADERSHIP CONFERENCE (Saturday, February 3):

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☐ Resident Physician	No Fee	$25
☐ Medical Student	No Fee	$15
☐ Auxiliary/Spouse	$25	

OPTIONAL SEMINARS (Sunday, February 4): Choose the one you wish to attend.

"MEETINGS WITHOUT MIGRAINES" ☐
Sponsored by Peachtree Parliamentarians

"TAX AND INVESTMENT TIPS FOR THE '90's" ☐
Sponsored by MAG Mutual Insurance Company

CHECKS SHOULD BE MADE PAYABLE TO "MEDICAL ASSOCIATION OF GEORGIA." Payment must accompany this form, and should be mailed by January 26. No refunds will be given after February 2.

DETACH THE TOP PORTION OF THIS FORM AND MAIL TO:

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Atlanta, Georgia 30392

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The Medical Association of Georgia's

Sixth Annual Leadership Conference

February 3-4, 1989

Westin Lenox Hotel
Atlanta

EACH YEAR, for all our members — but especially for those Georgia physicians holding positions of leadership in MAG, their county medical societies, specialty societies or hospitals — the Medical Association of Georgia sponsors a Leadership Conference, our major update on all the late-breaking trends in medical legislation and socioeconomics. It's an important meeting — full of information, pressing topics, and stellar speakers. This year our MAG Leadership Conference will be held February 3-4 (Saturday and Sunday), in Atlanta at the Westin Lenox Hotel.

Once again our agenda focuses on the major forces affecting your practice: Medicare regulations, reimbursement problems, state and federal legislation, as well as the "big picture" — what lies ahead for all of us in American medicine.

Our complete Conference Program is presented here, along with your Leadership Conference registration form. If you haven't registered yet, we invite you to examine our program and then join us at the meeting for Georgia physicians' most comprehensive update on the legislative issues facing medicine.

Leadership Conference Highlights

Saturday, February 3

Gubernatorial Candidates to Speak

1990 is election year in Georgia, and we have a real race for the Governorship. The new Governor will play a pivotal role in shaping state policies toward health care delivery and the medical profession. Therefore, we have invited each of the five major gubernatorial candidates to present their views on health care issues: Lieutenant Governor Zell Miller, State Senator Roy Barnes,

State Representive Johnny Isakson, State Representative Lauren McDonald, and Atlanta Mayor Andrew Young. Each will speak briefly, then the program will open for discussion. Come ready with questions.

Mandatory Assignment

One of the most critical medical-legislative issues involves mandatory assignment. In the last Session of the Georgia General Assembly, several bills were introduced which would have required physicians to accept Medicare and Medicaid patients as a condition of medical licensure. The bills were defeated, but they will be back in the 1990 Session.

What are the arguments for and against mandatory assignment? We have lined up two of the top spokespersons in the state: Vita Ostrander, Executive Director of the Georgia Chapter, American Association of Retired Persons, and MAG's Past President Joseph P. Bailey, Jr., M.D.

AEtna and HealthCare COMPARE

By now, nearly every doctor in the state is no doubt aware of the problems we have been having with the new Medicare intermediary in Savannah, AEtna, and its utilization review subcontractor, HealthCare COMPARE. Backlogged claims, downcoding, improper medical judgments, and administrative errors have all been part of the mess this past year. What has MAG done about all this? Will things improve? We will present an update at this Conference.

Jeffrey Nugent, M.D., Chairman of MAG's Public Relations Committee, will also tell us how we're trying to inform our older citizenry about the abuses and inequities of the Medicare system that affect them.

Dr. Todd on "Expenditure Targets"

Medicare, of course, is just part of the big issue facing American medicine: how much federal government regulation will be enacted upon physicians across the nation. Dr. James S. Todd, the AMA's Senior Deputy Executive Vice President, will be on hand to tell us how the American Medical Association has been fighting governmental efforts to implement "expenditure targets" which would cap federal reimbursements to providers. And an important member of the House Energy and Commerce Committee who has helped Medicine for a long time, Congressman Ralph Hall from Texas, will present his views on the future of federal regulation of physicians.

Lunch

Lunch will be on your own, except for "young physicians." Those MAG members who meet the criteria of the MAG Young Physicians Section (YPS) (under 40 years of age, or in their first 5 years of practice) are invited to a special YPS luncheon. We gratefully acknowledge the support of Smith, Kline, Beecham for this event.

U.S. Representative Newt Gingrich

For the afternoon session we have invited as our Special Guest Speaker United State Representative Newt Gingrich, of Georgia's 6th District. Congressman Gingrich has never addressed a major MAG conference before, so we especially hope his Washington schedule will allow him to present his perspective on the health care issues facing the American people.

National Practitioner Data Bank

Just last month, new federal regulations were released implementing one of the most significant programs affecting physicians in the United States: the National Practitioner Data Bank (NPDB). The NPDB is the government's new system for storing data on every physician in the country regarding liability settlements and peer review actions. Who has access to this critical data? And what safeguards do doctors have to insure its accuracy? Andrew Watry, of Georgia's medical licensing board, will answer questions.

Physician Referral to Self-owned Facilities

California Congressman Fortney ("Pete") Stark is certainly no friend of Medicine these days. One of the bills he's tried to pass would ban all physicians' referrals to facilities in which they or a member of their family have made investments. The AMA has pointed out that many of these referrals are not abusive, but are in the best interest of patient care. Who will win? Janet K. Horan, Legislative Attorney with the AMA in Chicago, who has been tracking the self-referral issue this year, will update us on this issue.

A National Health Care System?

Finally, we look down the road, toward the possible evolution of American medical care delivery. As private practice has changed dramatically over the past few years, some of our leaders have been advocating a much more drastic change: a government-financed system of health care for all Americans, similar to the Canadian government's program.

Several thousand American physicians are calling for this kind of Canadian system for the U.S. David Himmelstein, M.D., a Harvard internist and a leader of the national organization of Physicians for a National Health Care System, will present the arguments for this system.

Speaking against it will be San Antonio internist Brant Mittler, M.D., who has been a national spokesman for "Physicians Who Care," which promotes traditional private practice for American medicine. Dr. Himmelstein and Dr. Mittler will engage in a "point-counterpoint" on Saturday afternoon.

Our session will conclude at 5:00. Immediately following, we invite all Leadership Conference attendees, spouses and guests to a reception, sponsored in part by *Georgia Trend* Magazine.

SUNDAY, FEBRUARY 4

Optional Workshops, 9 A.M. — Noon — Choose One!

Workshop A

"Meetings Without Migraines"

A 3-Hour Seminar in Basic Parliamentary Procedure Designed Especially for Physicians

Medical Society Officers, Hospital Chiefs of Staff — you have been chosen by your peers for a leadership position. Effective leaders quickly learn that a key quality is knowledge of correct parliamentary procedure. Conducting meetings confidently and fairly with a minimum of wasted time will win you the respect and thanks of your colleagues.

To help you learn the "rules of the game" applying to business meetings, the MAG is offering "Meetings Without Migraines." Our faculty will be Mary Lou Stephens, and Julia vonHaam. Both are Professional Registered Parliamentarians and are married to physicians practicing in Atlanta. They have prepared materials specifically for physicians to teach you the procedural skills you need for:

- Debate: controlling discussion/ rules of debate
- Decisions: determining consensus, expediting business/motions to accomplish your business
- Delegates: being an effective representative, serving in the MAG House of Delegates and on Reference Committees.

(This is an "encore performance." So successful was Mrs. Stephens' and Mrs. vonHaam's seminar at last year's Leadership Conference that we are offering it again.)

Workshop B

"Tax and Investment Tips" For the '90's"

A 3-Hour Seminar for Physicians Sponsored by MAG Mutual Insurance Company

MAG Mutual has developed a special workshop to assist physicians with their practice finances and investment planning. Principal instructors will be Steve Barton and Coy D. Uard, Financial Consultants at MAG Mutual. They will cover such topics as:

- *Qualified Retirement Plans* and the new problems with Defined Benefit Plans.
- *Welfare Benefit Trust* — How to receive tax-free retirement funds in a non-qualified, fully discriminatory retirement plan paid for by your corporation.
- *Estate Planning* — Using the annual exclusion, the double unified credit, and discounted dollars to reduce taxation by 85%.
- *Financial Planning* — How to get tax-deferred growth without losing access to your money.
- *Controlling Employee Health Care Costs* — Funding alternatives, cost containment, plan design changes, employee education.
- *Business Continuation Agreements* — Buy/Sell, Key Man, Overhead Expense, and insurance to fund the agreements.
- *How to Avoid Section 89 Testing & Compliance* — Section 89 deals with discriminatory acts concerning employee benefits.
- *Personal Disability Income* — There are many types; what best protects those in the medical profession?
- *Charitable Remainder Trusts* — A plan to reduce current income tax, estate tax, and receive income simultaneously.
- *The Banking Crisis* — What really are the rules and the guarantees? How to find out if your bank is healthy.
- *Future Possibilities for Law Changes* — Tax increases, capital gains, mutual insurance companies, and IRA deductions.

Registration for the Meeting

To register for the 1990 MAG Leadership Conference and optional workshops, please complete the registration form inserted in the *Journal,* detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

Your fee covers the full program and reception on Saturday plus your choice of one of our Sunday seminars.

February 3-4, 1990

	MAG Member	Non-Member
Physician	**$85**	**$185**
Resident Physician	**No Fee**	**$15**
Medical Student	**No Fee**	**$15**
Auxilian/ Spouse	**No Fee**	**$25**

Hotel Accommodations

The MAG has secured an attractive guest room rate at the Westin Lenox Hotel, which conveniently adjoins Lenox Square and is near Phipps Plaza. The rate for both singles and doubles is $90. To make your reservations at the Westin Lenox, you may use the detachable lower portion of our Leadership Conference registration form, and mail it directly to the Hotel. Cut-off date for MAG reservations is January 11; after that, rooms are on a space-available basis.

Dear Editor:

I was pleased to see Dr. Robert Fore's excellent article, "Continuing Medical Education Requirements for Hospital Medical Staffs in Georgia," in your December *Journal*. Not only does the article provide a useful perspective on the status of mandatory CME across the country, but is points out the considerable flexibility of the JCAHO's requirement regarding CME participation by hospital medical staff members.

I think Dr. Fore's survey findings indicate two significant points:

1) Continuing medical education in hospitals is increasingly important. The word seems to be out that some form of mandatory CME requirements will inevitably be passed by the Georgia Legislature. Hospital administrators and medical staff members alike, therefore, see the local hospital serving as a logical provider of CME to help physicians meet these needs.

2) Even without a legislated minimum CME requirement in Georgia, or a minimum CME requirement for staff privileges in most hospitals, participation in CME must still be documented by the physician in order to meet hospital or specialty society expectations. In other words, it's not enough for a doctor to attend CME meetings; he or she must document this participation through conference sign-in sheets, earned credit certificates, or other records.

Ours is a profession predicted upon commitment to a lifetime of learning. From here on, either to satisfy our hospitals' JCAHO standards or to meet our state's relicensure requirements, we must assume the additional responsibility of documenting our CME participation. I agree with the need for such record-keeping. My hope, though, is that "administrivia" does not overwhelm the benefits of continuing education or detract from the sheer pleasure each of us receives through continuous learning in our profession.

Sincerely,
Hillary R. Newland, M.D.
Pathologist, Athens
Chairman, MAG Committee on Continuing Medical Education

QUOTES

Quackery and idolatry are all but immortal.

O.W.HOLMES:
The Medical Profession in Massachusetts, 1869 (Lecture in Boston)

Each loves itself, but not itself alone,
Each sex desires alike, till two are one,
Nor ends the pleasure with the fierce embrace;
They love themselves a third time in their race.

ALEXANDER POPE:
An Essay on Man, III, 1733

Nature never intended man to be a low, grovelling creature. From the moment of his birth she implants in him an inextinguishable love for the noble and the good.

LONGINUS:
On the Sublime, XXV, c. 250

Mankind are very odd creatures: one half censure what they practise, the other half practise what they censure; the rest always say and and do as they ought.

BENJAMIN FRANKLIN:
Poor Richard's Almanac, 1752

Our sex's weakness you expose and blame,
Of every prating fop the common theme;
Yet from this weakness you suppose is due
Sublimer virtue than your Cato knew.
From whence is this unjust distinction shown?
Are we not formed with passions like your own?
Nature with equal fire our souls endued:
Our minds as lofty, and as warm as our blood.

MARY WORTLEY MONTAGU:
Letter to James Steuart, July 19, 1759

Morality in sexual relations, when it is free from superstition, consists essentially of respect for the other person, and unwillingness to use that person solely as a means of personal gratification, without regard to his or her desires.
BERTRAND RUSSELL
Marriage and Morals, XI 1929

In their choice of lovers both the male and the female reveal their essential nature. The type of human being which we prefer reveals the contours of our heart.
ORTEGA Y GASSET

All are not friends that speak us fair.
JAMES CLARKE

It is a fact that great eaters of meat are in general more cruel and ferocious than other men; this observation holds good in all places and at all times; the barbarism of the English is well known.
J. J. ROUSSEAU: *Emile, I, 1762*

A rich man is nothing but a poor man with money.
W. C. FIELDS

Of the Beginnings and Endings of Life

Charles R. Underwood, M.D.

"Is the preservation of life, or its termination, a matter for the individual woman and her physician to arbitrate or does that decision rest in the bosom of the body social?"

He had wandered into the country doctor's office that morning, the young girl's father had. Overalls and brogans replete with sweat and mud testifying to his way of life. Testifying, also, it might seem to some, to his insight into things personal. Into things ethical. Testifying perhaps also to his schooling, to his sophistication.

"She's been knocked up, Doc," he reported as the 16-year-old daughter lingered behind him. Her head hung between the strands of dusty and stringy hair. The evocative outlines of her body stretched the polyester skirt and blouse beyond dimension. A fragrance recalling the blooms of spring, jasmine, and lilac floated through the air, engulfed and permeated the room in which they found themselves. They stood there in the confines of the examining room, the three of them, with past experience and formal opinion fomenting in the cauldron of decision making. One searching for surcease from shame. One grasping for a foothold into the future. One recalling rules, guidelines, principles, ethical decisions, desperately looking, grasping from the ever-elusive answer. So it was for the physician, hoping against hope, that from all the reading, the lectures, the Biblical study, the pronouncements, the preachings of parent and pastor alike, surely that from all of this would come as a tablet from the mountain, as bright as a burning bush, surely the answer would come.

"They stood in the confines of the examining room, the three of them, with past experience and formal opinion fomenting in the cauldron of decision making."

The answer to the two of them came quickly and easily. To the third, the agonizing physician, it came with maddening slowness if it came at all. So simple it seemed. Clear the "problem" from the suffering body. Or, refuse to do so. "Go home with your shame, your intemperance, your giddy emotions, your 'love,' your quivering, pulsating genitals. Go home and rearrange your life. Go home and prepare the bassinet. Welcome to our world, mother."

The bells of decision making rang with relentless constancy about him. Engulfed him. "Where, oh my God, where are you? Where is the answer?"

"Bring her back tomorrow. It would be best if early. She should be all right afterwards. She can have children later. She will be normal. Trust me."

I learned about abortion at the age of 16. Too young, too immature, too unread, too unprogrammed, too foolish, and too sexually girdled to know or understand or really care about "problems" or ethics. Girls were girls, and boys were boys, and ever the twain should meet. We had but one concern to stay out of "trouble." But then the learning began.

It was a small rural hospital. No DRGs there, nor CME conferences, nor peer review. Only carefully selected pathology reports. We lived in that hospital in a pathologic Shangri-La. No questions asked in our world. We lived, we performed, we decided, we operated as our whims, our unrestrained and personally developed ethics and morality told us to. We were in Camelot.

"What funny little pigs," she said pulling the formalin-filled laboratory jars, sealed these many years, from beneath their carefully concealed hiding place. We were in the basement that Saturday morning, the only daughter and myself, happily fulfilling that human desire genetically imprinted at conception to make order from disorder by way of "straightening up the basement." "Nothing of importance," I told her. "Just something I came across in high school. You wouldn't really be interested in where they came from."

"We were in the basement that Saturday morning . . . happily fulfilling that human desire genetically imprinted at conception to make order from disorder by way of "straightening up the basement."

I had arrived at Emory with those formalin-filled jars containing the little "pigs" some years before the basement conversation with our daughter. Perhaps at the time the best collection of early human fetuses in the city. They had come from a careful screening of the debris in the kickbuckets in the operating room of a small country hospital by a young teenager unaware of the swirl of debate that the years ahead would generate about such matters.

The time comes again as it has come so often through the ages when we must confront the issue of abortion. Come to grips with, or at least wrestle with, our ethics. With our morality and our religion as those bases for decision making lead us to a position, to an opinion in this regard. We cannot avoid it. Indeed, does life begin at conception when egg meets sperm? Does personhood arrive at the 20th week unheralded, unpredicted, and wanted or unwanted? Is privacy, the sanctity of the female body, a God-given right or shall it be a matter best left to the personal opinion of nine learned women and men? Is the preservation of life, or its termination, a matter for the individual woman and her physician to arbitrate or does that decision rest in the bosom of the body social? Is abortion, the destruction of the quickened or unquickened fetus, related in any way to the welfare, the social milieu, upon the threshold of which the unborn person rests? Do our decisions, our opinions need rest and find their solace in *Roe vs. Wave* — 1973 and *Webster* — 1989 or is there room for the person now brought to life to impact those decisions and those opinions?

I looked back at the formalin filled jars and their residents. Was there a president there? A professor? A maniacal rapist? An eminent theologian? A Supreme Court Justice? A physicist with the illusive answer as to where we came from and to where we travel? Indeed — was I there?

"And God blessed them, and God said to them, "Be fruitful and multiply, and fill the earth and subdue it; and have dominion over the fish of the seas and over the birds of the air and over every living thing that moves upon the earth."

GENESIS 1:28

"If it should happen among married people, that a woman who already had the prescribed number of children, became pregnant, then before she felt the life the child should be driven from her."

ARISTOTLE

"I will follow that method of treatment which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any counsel; furthermore, I will not give to a woman an instrument to produce abortion."

HIPPOCRATIC OATH

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

"Abortions should be performed by a properly qualified Doctor of Medicine. The procedure should take place in a hospital or clinic that has personnel and facilities which will provide adequate protection against infection, and proper equipment to combat blood loss, shock, or respiratory distress.

"Physicians must have the right to refuse to perform abortion for any reason.

"Abortions should not be carried out after a gestation period of 20 weeks has passed.

"State funds should be made available for abortions."

ACTION POLICY STATEMENTS MAG, 1983

"Protestants have long affirmed the use of contraception as a responsible exercise of stewardship of life. To prevent pregnancy when it is not desired is to be a responsible steward of human life. However, in the exceptional case in which a woman is pregnant and judges that it would be irresponsible to bring a child into the world, given the limitations of her situation, it can be an act of faithfulness before God to intervene in the natural process of pregnancy and terminate it."

STUDY DOCUMENT, PRESBYTERIAN CHURCH IN THE UNITED STATES

"We need not resolve the difficult question of when life begins."

MR. JUSTICE HARRY BLACKMUN, SUPREME COURT, 1973

"The amount of information stored in a two-cell embryo is five times greater than all the information found in the Encyclopedia Britannica. At the moment of conception, all the characteristics of the new being are there. . . . I cannot see a difference in early human beings and a late human being because they are from the same species. Just because they grow older doesn't mean they change species."

DR. JEROME LEJEUNE, DIRECTOR OF THE FRENCH NATIONAL CENTER OF SCIENTIFIC RESEARCH TESTIFYING IN THE MARYVILLE, TENNESSEE, TRIAL CONCERNING FROZEN EMBRYOS.

"When Rachel saw that she bore Jacob no children, she envied her sister; and said to Jacob, "Give me children or I shall die." Jacob's anger was kindled against Rachel, and he said, "Am I in the place of God, who has withheld from you the fruit of the womb?"

GENESIS 30:1-2

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

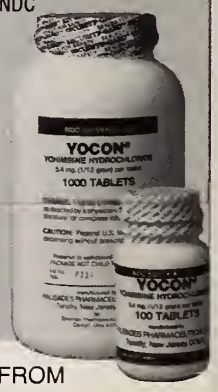
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Personal Thoughts on Abortion

A WOMAN we know writes: On the way to Washington to attend the march for abortion rights last weekend, I passed through Elizabeth, New Jersey, where more than twenty years ago I had an illegal abortion. I won't go into the details of my situation then except to say that I had been forced to make a choice, and did, but it was a choice made on a sea of helplessness. It was not something I could talk about at the time, and I went through the experience silently and alone.

On Sunday morning, I walked to the Washington Monument, where the rally before the march was held, and my first impression on seeing hundreds of thousands of people gathered there was of the continuing emergence of women from decades of silence and isolation. My second impression was that there must have been thousands of individual stories comparable to mine which had brought people there. I felt an extraordinary comfort as my story took its place among them. The authority that day lay not with the speakers but with the listeners, in their inwardness and variousness. There were many men in the crowd, and they were welcome, but the main people that day, it seemed to me, were the women.

In the normal course of life, a woman's body is invaded and used and used up in a way that has to do directly with her reproductive system. In her childbearing years, a woman's bodily life is always pressing on her consciousness, through menstruation, and through the very-present possibility of pregnancy, if not pregnancy in fact. It's a matter of course for a woman to have a special doctor, whom she visits regularly, to look after her reproductive system and the many small problems that can arise there — not to mention the large ones. The life of a woman's body is written in stretch marks, missing breasts, a scarred uterus, the scar of a cesarean birth, of a hysterectomy. And there are dark experiences like incest, rape, and my own illegal abortion, which for many make up a shadow history. All this experience was present on the Mall last Sunday.

What that presence was saying, it seems to me, is that abortion is an issue of bodily sovereignty. The jurisdiction of the government ends at the boundary of my body. Within that boundary I am the sovereign. I choose what values govern there. I can say, as many say, that within my kingdom a fetus has unconditional protection. I can say, as I do say, that abortion represents an irreplaceable human loss but that there are times in my kingdom when that loss must be endured. I do not say, as the most radical feminists do, that an abortion has the same significance as a tonsillectomy, or even less — that it is a form of birth control, no different from using a diaphragm or a contraceptive pill. Such a position puzzles me, because it seems to defy both the facts and the emotional truth as I have experienced it. Yet in my view the women who say this have an absolute right to do so, for every woman must be allowed to reign over her own body. And for the federal government the radical-feminist position is the correct one, for the government, that is, an abortion and a tonsillectomy *should* be equivalent, in the sense that the government should have no more right to deprive a woman of one than of the other. To me, there is some difference, but not much, between a government that says you can't have an abortion

"What that presence was saying, it seems to me, is that abortion is an issue of bodily sovereignty. The jurisdiction of the government ends at the boundary of my body."

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and a government, like China's, that in certain cases says you must.

The abortion issue relates to deeply personal levels of life which are rarely brought into the political arena. But the requirements of maintaining political momentum have tended to block those layers of feeling from which the issue arises in the first place. There was a small counter-demonstration at the Washington rally which deployed a kind of fetal pornography — pictures of aborted fetuses — and placards expressing paranoia and hate. There were also women praying. They were, I believe, really praying. Their gesture was incongruous with the rah-rah aspects of the march, and yet this praying arose from a level of feeling appropriate to the largeness of this issue. I disagreed with these women politically, but I also felt that they, and the sentiments they were expressing, belonged *with* us marchers, and not against us. I felt that their feelings, too, arose out of the female bodily experience. In fact, I was more comfortable with their sentiments than I was with some of the pro-choice rhetoric — especially the militant assertion that a woman's rights override the rights of a fetus. Full-grown, healthy human beings cheering for their precedence over the most vulnerable form of human life did not seem to me to be a glorious triumph. For me, the special meaning of the day, of my history in common with other women, was that I was able that evening to relive my experience in Elizabeth, New Jersey — to remember the fierce despairing love that I had felt for the vague half-being forming within me as I was driven blindfolded and alone to a motel; to remember how the men in attendance were lewd and flippant; to remember disappearing into the darkness of the anesthetic — and, remembering these things, to weep wholeheartedly for the first time. ■

"The abortion issue relates to deeply personal levels of life which are rarely brought into the political arena. But the requirements of maintaining political momentum have tended to block those layers of feeling from which the issue arises in the first place."

Providing Physicians to Rural Georgia: How Successful Are We?

W. Douglas Skelton, M.D., G.E. Alan Dever, Ph.D., M.T.

THE CRITICAL NEED for primary care physicians to practice in rural Georgia has been emphasized in a variety of publications. The August, 1989, issue of the *Journal of the Medical Association of Georgia* included two articles and one editorial on this subject. The existence of the need is not under debate; successful means of alleviating the need are.

"Is a medical school designed to produce primary care physicians for the state's rural areas the appropriate solution to the crisis of rural physician supply in Georgia?"

Early in this decade, the Mercer University School of Medicine opened with one of the most defined missions of any medical school nationwide. The principal component of that mission — to provide primary care physicians to rural Georgia — was the rationale for the state investment in Mercer. At that time, and continuing even until today, critics state that no medical school can succeed in such an effort. While it is too soon to make definitive statements as to the success of the Mercer format, information from the few graduates now in practice and the graduates currently in residency programs indicate high probability of success.

Of the 22 initial graduates, 87% selected a primary care specialty; 45% of these selected family practice. All 11 members of this class who have begun or will begin practice in 1989 selected a primary care specialty; 64% were in family medicine, 27% in internal medicine, and 9% in pediatrics. Nine of the 11 graduates elected to practice in counties with a population less than 50,000. The remainder of this class will be available for practice at some point in 1990 or early 1991. It appears their choices will be similar.

According to data from the American Medical Association and published in the March-April, 1989, issue of *Family Medicine*, Mercer ranked 16th in the nation for the number of graduates who entered a family practice residency program upon graduation. The Medical College of Georgia ranked 76th, and Emory University School of Medicine ranked 107th. These ranks were based on an average percentage for the last 8 years. Mercer's average percentage of graduates entering family medicine was 20.3%. The Class of 1989 had 35% of its graduates entering family practice, which would elevate Mercer's overall average of graduates in family medicine to approximately 27%. This average would increase Mercer's rank to fourth in the nation. Again, family medicine is only one of the primary care specialties. Internal medicine, obstetrics and gynecology, and pediatrics are chosen by most of our other graduates. A few choose general surgery and psychiatry. To our knowledge, only three have chosen specialties outside our mission.

Dr. Julian Dutterer, in his editorial on p. 531 of the August issue of the *Journal of the MAG*, commented on the lack of any students selecting family medicine from the Class of 1988. While none of the 19 graduates entering their residencies in 1988 selected family medicine, 17 did select other primary care specialties, and two entered transitional programs. Mercer's program is not limited to family medicine; it includes all of the primary care disciplines plus general surgery and psychiatry. All of these specialties are needed in

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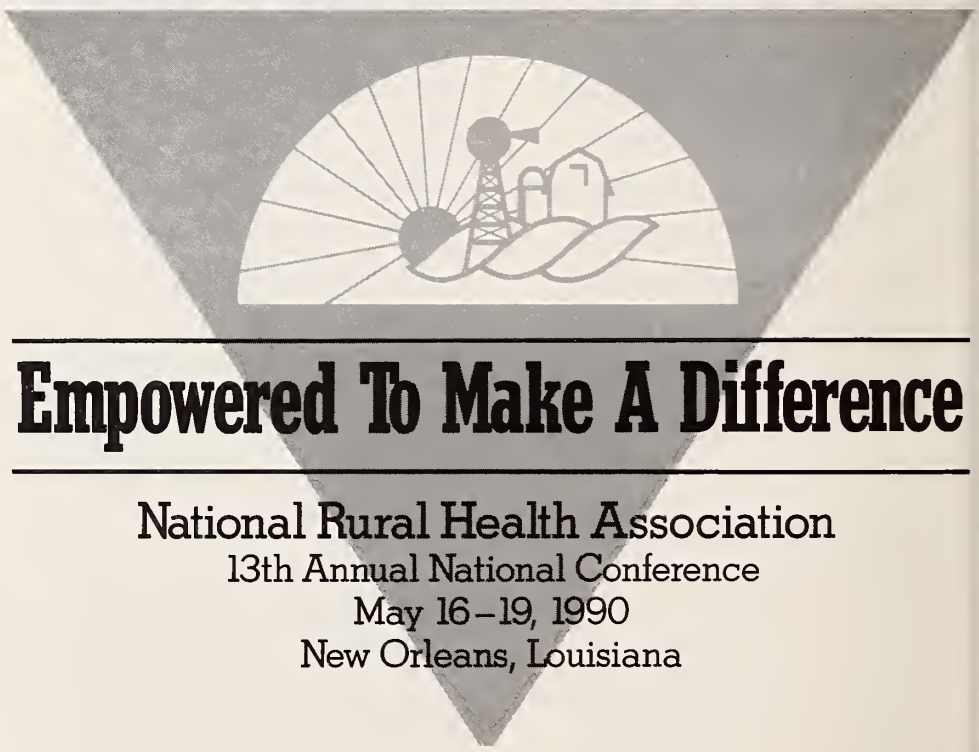
"The existence of the need for primary care physicians in rural areas is not under debate; successful means for alleviating the need are."

rural and other medically underserved areas of Georgia.

Is a medical school designed to produce primary care physicians for the state's rural areas the appropriate solution to the crisis of rural physician supply in Georgia? While it is not the sole solution, it is proving to be a successful strategy that — combined with other state and federal initiatives — could do much to lessen the critical situation that now exists. Are we mission compliant? Both the AMA data and our own indicate that we are. ■

RURAL HEALTH!



Empowered To Make A Difference

National Rural Health Association
13th Annual National Conference
May 16–19, 1990
New Orleans, Louisiana

The Cure for Those Turf War Blues

John R. Leyendecker, M.D.

HAVE "TURF WARS" got you down? Well, you're not alone. Maybe you are a neurosurgeon who would rather be doing your own MRI. Perhaps you are a general practitioner wondering whether to send that skin lesion on the neck to a dermatologist, a general surgeon, or an otolaryngologist or to remove it yourself. Or are you a radiologist worried about that clinician who is going to attend a conference in Vail, Colorado, to learn in 3 days what it took you 4 or more years to become specialized in (and learn to ski in the process)? The current tend is toward more and more competition for those coveted procedures, and as a result, more tension between the specialties. But, there is hope. Allow me to introduce the concept of D-TERFs (Diagnostic and Therapeutic Equipment Rental Facilities).

Modeled after those highly successful do-it-yourself businesses that allow you to frame pictures or move your belongings at a fraction of the usual cost, D-TERFs bring with them the promise of financial reward and harmony between the specialties, while at the same time reducing this country's health care bill. Soon, that frustrated neurosurgeon will be able to meet his or her patient at the nearest "Roent-all" and do his or her own MRI. Cheerful and courteous on-site professionals (enter the radiologists) would be on hand to aid in recipe selection, interpretation, or further evaluation on request, each for an individual and modest fee.

"Modeled after those highly successful do-it-yourself businesses that allow you to frame pictures or move your belongings at a fraction of the usual cost, D-TERFs bring with them the promise of financial reward and harmony between the specialties."

Each D-TERF would also carry a equipment including mobile scanners and ultrasound machines. What about invasive procedures like angioplasty or embolization? No problem! With detailed, step-by-step instructions in a variety of languages and highly trained personnel close at hand to walk you through those sticky spots, D-TERFs would make that arterial stick as easy as A-B-C!

If you don't have time to do another 4 years of residency, but you'd still like to cash in on those procedures, then D-TERFs are for you. And with a rent-to-own option, what group could afford to buy their own equipment? With D-TERFs, everyone would win. The clinician would be able to do procedures with as much or as little supervision as he or she desired, the radiologist would not have to worry about clinician-owned diagnostic facilities, the generalist would be removed from the endangered species list, and the patient would save money. And, of course, malpractice woes would be put to rest with optional coverage available at daily, weekly, and monthly rates.

I am so certain that D-TERFs are the wave of the future, that I predict we will soon be seeing "Roent-alls," "Scoper's Workshops," and "Cath-a-ramas" opening all over the country. Let's put an end to the age-old battle between the specialties and show the world that we can have our cake and catheterize it to! Support your local D-TERF. ■

Dr. Leyendecker is a Resident in Radiology, Emory University Affiliated Hospitals. His address is 1129-C Clairmont Rd., Decatur, GA 30030.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physicians Recognition Award (PRA) July through September, 1989.*

The award was established by the AMA House of Delegates in 1968 "To recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review, at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category 1 credit by organizations accredited for these activities.

We can congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Agraz, Rodolfo R., *Marietta*
Alvig, Olav Henry, *Cumming*
Aranas, Catalina T., *Columbus*
August, Garry L., *Columbus*
Barry, Wm. Earl, *Athens*
Berenson, Morton, P., *Columbus*
Berg, Jos. Leonard, *Albany*
Bohler, Clorinda Scarpa S., *Augusta*
Bronersky-Enumah, Lois E., *Columbus*
Butler, Jack A., *Unadilla*
Cabral, Justo F., *Valdosta*
Carson, James M., *Atlanta*
Cheek, Benjamin H., *Columbus*
Chelton, Alice K. G., *Atlanta*
Cook, Ernest L., *Atlanta*
Cooper, Jerry Lee, *Decatur*
Daily, F. Willson, *Savannah*
Daugherty, Dwayne T., *Norcross*
Davidson, John A., *Atlanta*
Davis-Williams, Camille, *Atlanta*
Degi, Keith Jos, *Atlanta*
Dharamisi, Mohamed N., *Conyers*
Dill, Lawrence Clyde, *Tifton*
Dobes, Wm. Lamar, *Atlanta*
Fadel, Hossam E., *Atlanta*
Felder, Louis H., *Atlanta*
Gallup, Donald G., *Atlanta*
Garland, Brenda, *Snellville*
Gauthier, Paul Denis, *Jeffersonville*
Geschke, Dietrich W., *Martinez*
Gilbert, Frederick E., *Newnan*
Glover, Ridley M., *Dublin*
Guzman-Ferry, Margarita L., *Dahlonega*
Hailey, Chenault W., *Atlanta*
Harjee, Gulshan S., *Decatur*
Herskowitz, Louis, Jack, *Austell*
Hissam, James E., *Savannah*
Holsenbeck, Linton S., *Martinez*
Hull, James D., *Douglasville*
Hutto, Mark Craton, *Atlanta*
Jarett, Paul Jeffrey, *Warner Robins*
Khankhanian, Nayereh K., *Atlanta*
Kilbourne, Edwin Michael, *Atlanta*
Larrauri, Manuel S., *Milledgeville*
Leddy, Michael Roden, *Cartersville*
Lee, Steven Richard, *Atlanta*
Long, Harold Glenn, *Dahlonega*
Maness, David Lonnie, *Augusta*
Manjunath, Bettadapura R., *Martinez*
Marino-Fuller, Brenda, Marietta
McRae, Sylvester, *Columbus*
Mohan, Palghat V., *Monroe*
Monteiro, Andrew Robt., *Warner Robins*
Moore, William W., *Atlanta*
Moretz, McCoy Lee, *Cartersville*
Musser, Ellyn Z., *Marietta*
Myers, Barnwell R., *Macon*
Nasca, Richard J., *Columbus*
Newland, Hillary R., *Athens*
O'Brien, John F., *Atlanta*
Patel, Swati Pankaj, *Marietta*
Philen, Rossanne M., *Atlanta*
Pirkle, Thomas N., *LaGrange*
Porter, Harry, *Atlanta*
Powers, Edgar B., *Norcross*
Prasse, Karen W., *Macon*
Rando, Stephen N., *Macon*
Rhango, Wm. Charles, *Savannah*
Sanders, Richard A., *Columbus*
Santigo, Armando C., *Milledgeville*
Schwartz, Seth A., *Riverdale*
Serrano, Gabriel, *Atlanta*
Shah, Mukta K., *Tucker*
Shapiro, Jeffrey D., *Atlanta*
Sharp, Cecil C., *Albany*
Siegan, Steven W., *Monroe*
Smith, Richard A., *Atlanta*
Sofley, Carl W., *Hinesville*
Stickland, Samuel L., *Albany*
Stubbs, O. Wytch, *Decatur*
Su, Shaw Cheng-Tsuau, *Savannah*
Sumner, Jean R., *Wrightsville*
Tarpley, Barry T., *Augusta*
Thompson, Bobby D., *Macon*
Turner, Joseph M., *Tifton*
Walicke, Patricia Ann, *Tifton*
Wardlaw, Joe Roy, Savannah
Watkins, Patricia N., *Augusta*
West, John H., *Savannah*
Whitaker, James Q., *Warner Robins*
Yancey, Asa Greenwood, *Atlanta*

From BYNUM'S Scrapbook

Come and See Me Operate

IF A MAN WISHES to improve himself, let him improve his work.

Dr. L. P. Jacks, one of Oxford's college professors, thinks Art is simply common work done uncommonly well. A good workman wakes up one morning and finds himself an artist.

One wonders what proportion of the people can apply this philosophy. Many of us can, but can the ordinary workman, the bricklayer, the bookkeeper, the restaurant worker?

A great surgeon once was asked to state his religion. "If you want to know what my religion is, come and see me operate," he said. Such, thinks Dr. Jacks, would be the answer of any good workman when you get him with his back to the wall! Come and see me operate in the field, the workshop, the factory, the office, the bank, the studio, the sinking ship, the typhus camp, or where any good workman should happen to carry on his business."

So with industrial civilization. Would you find out what London, Paris, New York, or Washington, D.C., really believes in, what its religion is. Go and see it operating. All work can somehow be lifted to this high plane, where men and women *will* approach their occupations with a kind of religious fervor. We fill our stomachs with the quantity of work, but we save our souls with the quality put forth.

Usually the men or women happy in their work, ask no greater happiness.

(Submitted by Richard Byrum Weeks, a retired surgeon, St. Simons Island.)

GHA Statement on Abortion

A motion was approved by the Board of the Georgia Hospital Association (GHA) adopting the following statement on abortion: "The Georgia Hospital Association (GHA) takes no position on the question of abortion. However, like other legislative changes that affect the quality and the public's access to health care, GHA insists that the state identify the resources hospitals can use to provide any additional care that legislative changes may require. GHA will evaluate each proposed change in the State's health care laws, including the abortion law and provide information to state officials on the cost impact of providing the care that becomes necessary as a result of any change in these laws."

GHA's Council on Government Relations Sub-committee also recommended that hospitals offer legislators the opportunity to learn more about the human biology of the entire birthing process, including both the intentional and unintentional termination of a pregnancy and the stages and scope of a completed gestation period. This opportunity would provide the legislators with an objective discussion of terminology, medical techniques and processes associated with gestation and would establish a helpful foundation for the political discussions that are underway.

Committee Studies Shortage of Health Care Professionals

Georgia's Joint Health Care Personnel Supply and Planning Study Committee met recently to finalize its report on the shortage of health care personnel in Georgia. The committee, which was created by House resolution in the 1989 General Assembly, is made up of legislators and representatives from all types of health care professions in Georgia. Rep. Eleanor Richardson (D) of Decatur is chairperson.

During four meetings this year, the study committee has heard testimony from allied health care professionals from throughout Georgia detailing the difficulties they face as a result of the shortage of health care employees. Georgia's Board of Regents has also reported on the need for more faculty in the state's health education program.

The committee earlier voted to develop a statewide data base to evaluate the health manpower shortage in all health care professions. In addition, it agreed to establish a policy planning committee to study the data and make recommendations on how to solve the problem. The policy planning committee will report to a legislative overview committee made up of three Georgia representatives and three senators who can, if needed, introduce legislation to help remedy the shortage.

According to the Georgia Hospital Associations, the collection of data from all health care professions is necessary to create a total picture of the shortage in Georgia and to understand how it affects the delivery of health care. Currently, only piecemeal data are available from individual professions, and there is no way to study the problem statewide.

Once the total data picture is in place, the policy planning committee will be able to make specific recommendations, such as the creation of scholarships, programs to develop student interest in the health care professions, and funding for additional faculty positions.

The Joint Health Care Personnel Supply and Planning Study Committee is the outcome of efforts Georgia Hospital Association (GHA) began nearly 2 years ago. At that time, the Association formed a group to study ways to balance the supply and demand for health care professionals and to gather information on the personnel needs of all types of health care providers. At the request of the GHA group, Rep. Richardson introduced the resolution to the Georgia legislature last year calling for the creation of the committee.

GHA Cites Medicare Losses

In press releases sent out as part of its Public Awareness Campaign, the Georgia Hospital Association (GHA) reports that the survival of hospitals is at risk if the federal government continues to cut Medicare funding.

Three out of every four Georgia hospitals lost money on Medicare in 1987, GHA reports, and 40% of the nation's hospitals are expected to lose money this year from uncompensated Medicare reimbursement. Medicare patients account for about 40% of hospitals' total patients.

Despite the losses hospitals are incurring, a survey conducted for GHA found that more than half of Georgians are not aware of what the DRG system is. In addition, the survey found that Georgians are unaware that Medicare covers only 74% of hospital charges.

Legislating Abortion Rights "With Justice For All"

U.S. Representative J. Roy Rowland

FOLLOWING THE SUPREME Court's July 3 decision giving states greater leeway in regulating abortion, President Bush and Congress have primarily confined themselves to the relatively narrow question of whether Medicaid funding for abortions should be extended to cases of rape and incest.

Both the White House and a Congressional majority have stayed clear of broader issues — such as prohibition versus free choice, point of viability, and parental consent. For now, such matters are being left to the courts and the states.

While Congress has dealt with a variety of abortion-related issues over the years, they have been mostly limited in scope. An example is this year's unsuccessful effort to allow Washington, D.C., to use its own financial resources to assist low-income women with abortions, something which has been permitted the states but denied to the District of Columbia.

Since *Roe v. Wade,* the 1973 landmark decision establishing a constitutionally based right to an abortion, the main abortion debate in Congress has involved Medicaid coverage. And it has been a roller coaster situation.

If the past is truly prologue (and I believe it is in this instance), then it will continue to be left to the courts and the states to settle the big uncertainties that now exist in abortion law.

In 1977, the first restrictive language was enacted to bar Medicaid funding "except where the life of the mother would be endangered if the fetus were carried to term." In subsequent years, Congress sometimes altered this language to include exceptions for rape and incest or for long lasting physical health damage to the mother. For the past few years, however, Congress has limited funding for abortions to life-threatening cases.

Representative Rowland is Georgia's United States Congressman from the 8th District. Send reprint request to him at 423 Cannon House Office Building, Washington, D.C. 20515-1008, ATTN: Selby McCash.

A year ago, a "rape and incest" provision was approved by the Senate but defeated in the House. This year, however, the House reversed itself and also approved the provision. It was then vetoed by President Bush. And an effort in the House to override fell 51 votes short of the required two-thirds majority.

Although they lost the fight, some Congressional proponents in favor of broadening the language in the Medicaid law to allow funding for rape and incest victims feel that momentum is on their side. They point out that the number of House members voting for the rape and incest provision increased from 166 to 231 over the past year. It is likely that another effort will be made in the 1990 Session to expand Medicaid funding in this area. The question is whether support for the provision will increase to the point where a Presidential veto can be overridden. It would take 290 votes to reach the necessary two-thirds majority.

Of course there is always a

chance that supporters of the rape and incest language may try to circumvent a veto when the issue arises again in the 1990 Session. Supporters may wait for an unrelated bill which the Administration strongly backs and then attach the abortion language to it as an amendment. This would put the President in a position of either not exercising his veto power or vetoing an entire bill just to kill that one provision. It is the kind of issue where no quarter is expected to be given by either side, particularly in an election year.

Chief Justice Rhenquist indicated that the state's interest in potential human life extends throughout the duration of pregnancy and that the requirement in the Missouri law for viability testing was constitutional.

Some people say the issue is more symbolic than substantive. Since it affects lives, it is certainly more than symbolic. It is true, however, that in 1979, the last time any statistics exist, only 72 of 1.6 million cases came under the "rape and incest" provision.

Congress has always had the option of dealing with the broader issues in the abortion debate. Constitutional amendments are introduced on abortion every session, some to prohibit abortions entirely and others to establish a state option in which some states might prohibit abortions and others could have no restrictions at all. Many far-reaching statutes have also been introduced, both on the anti-abortion and pro-choice sides. Hearings have been held on a few of these measures, and a couple have even been scheduled for a vote. But none have actually reached the floor of the House or Senate.

If the past is truly prologue (and I believe it is in this instance), then it will continue to be left to the courts and the states to settle the big uncertainties that now exist in abortion law.

In last July's decision in *Webster v. Reproductive Health Services*, The Supreme Court appeared to come close to adopting the state-option approach. On the question of viability, for example, the court overruled the earlier court's position in *Roe v. Wade* that "only after the first trimester does the state's interest in protecting maternal health provide a sufficient basis to justify state regulation of abortion. . . ."

Instead, the Supreme Court's latest abortion ruling upheld the Missouri law which, among other things, requires physicians to perform testing for viability at 20 weeks of pregnancy. In effect, this creates a presumption of viability at 20 weeks, although this presumption can be overturned by medical judgment and testing.

The Court put in doubt the future application of *Roe's* trimester framework and even questioned the reliance by *Roe* on the concept of viability, saying: ". . . we do not see why the State's interest in protecting potential human life should come into existence only at the point of viability, and that there should therefore be a rigid line allowing state regulation after viability but prohibiting it before viability."

Chief Justice Rehnquist indicated that the state's interest in potential human life extends throughout the duration of pregnancy and that the requirement in the Missouri law for viability testing was constitutional because it "permissibly furthers the State's interest in protecting potential human life." Instead of applying the strict scrutiny analysis used in *Roe*, the court opened the way for a lesser standard of review. It is much easier for a state to show that its regulations permissibly further its interest in potential life than it is for it to establish that there is a compelling state interest for restrictions. A "compelling state interest" is the test required by *Roe v. Wade*, and under it the majority of state regulations respecting abortion have been held unconstitutional. However, under the new standard, more state restrictions will probably be able to pass constitutional muster.

The lack of better viability tests could become increasingly important if the Supreme Court continues to move away from a trimester approach based on medical judgment.

At the moment, the impact of the Court's decision on viability is unclear. Technical advances in recent years have made 24 weeks the generally accepted point of viability for much of the medical community. Currently, less than 1 percent of all abortions are performed after 20 weeks, and physicians are already testing women seeking abortions during the second trimester.

The lack of better viability tests could become increasingly important if the Supreme Court continues to move away from a trimester approach to an approach based on medical judgment.

Along with viability, a whole range of issues, including restrictions on public abortion funding and parental notification laws, remain up in the air. In this atmosphere of uncertainty, most states are moving slowly, if at all, in changing abortion laws. The Supreme Court is scheduled to hear three cases on abortion during the Court's new term, and more definitive rulings may be forthcoming. The President and Congress, like the public at large, will be watching and waiting. ■

Choices: Contraception, Pregnancy, Birth, and Abortion

Luella Klein, M.D.

MOST WOMEN say they would like to have two children, begin childbearing in their twenties and have completed their family by age 30, although some career women are now postponing pregnancy until after age 30. Reproductive life spans about half of a women's adult life. Women spend most of their reproductive lives trying to keep from becoming pregnant. Without contraception, the fertile, sexually active woman would on the average have 14 births or 31 abortions, a fertility pattern present in some countries.* While barrier contraceptives were available and legal, the birth control pill (the "Pill") marketed in 1960 was a great breakthrough in contraceptive effectiveness, providing women with a choice of control of their fertility and control of their lives. Today most women look at fertility and their reproductive capacity of more than 30 years, and choose to prevent pregnancy with conception, often ending childbearing with tubal sterilization.

However, contraceptives have failure rates — pills about 1% with perfect use, and with less than perfect use about a 6% failure rate. About 10 million U.S. women using oral contraceptives, with a 1% failure rate, results in 100,000 unplanned and usually unwanted pregnancies annually; a 6% failure rate results in 600,000 pregnancies that women were trying to prevent. For condoms, diaphragms, cervical caps, and sponges, the average failure rates are from 11 to 18% annually. Contraceptive failure rates for all contraceptives available in the U.S. except pills and IUDS average more than 10% annually. Side effects and fear of side effects play a large role in contraceptives use and contraceptive-use effectiveness rates. The U.S. has the poorest contraceptive-use rates with the highest failure rates among developed countries.

Believing that it is a woman's choice whether to carry a pregnancy to term rather than that of a politician's or other's right to prevent that choice does not make one Pro Abortion.

U.S. Teen Pregnancy and Abortion vs. Other Western Countries

We are a reproductively illiterate nation. A Gallup poll conducted for the American College of Obstetricians and Gynecologists found that 76% of U.S. women thought that oral contraceptives were a significant health risk more dangerous than childbirth. Only

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*Numbers of live births and abortions may vary slightly from year to year, and age breakdown is not always available. Data are from Abortion Services in the U.S., each state and metropolitan area; Teenage Pregnancy in the U.S.; Adolescent Pregnancy in the South; and DHR Vital Statistics, State of Georgia.

Contraceptive failure rates in the U.S., except with the pill and IUDs, average more than 10% annually.

16% correctly thought that childbearing was a greater risk than birth control pills and 31% of women believed the Pill causes cancer. It is no wonder that with each newspaper headline which distorts the risk of various contraceptives, their use drops and unwanted pregnancy results.

We are also poorly informed about abortion. The U.S. recently (1985) has had about 3.7 million live births and an estimated 1.59 million legal abortions, for a ratio of 1.6/3.7, i.e., 40% as many legal abortions as births. This is a sobering reminder of our poor conceptive use, contraceptive failure rates, and the funds which we spend for contraception for those who are dependent on public sources of family planning.

Legal abortions are under reported, as some states do not require abortion reporting, and many women obtain abortions in physicians' offices to avoid abortion reporting and maintain confidentiality. If spontaneous abortions (miscarriages) are added to this total, more than half of pregnancies do not result in a live birth.

Also, the U.S. has the highest teenage pregnancy rate in the developed world, more than twice that of Canada, France, England, and Wales; three times that of Sweden; and nearly seven times that of the Netherlands. Teenagers in these countries all begin sex at about the same age as those in the U.S. and with the same frequency (slightly earlier in Sweden and later in Canada). However, these other countries provide straightforward sex education and contraception, usually birth control pills, to teenagers, with resultant low rates of pregnancy, birth, and abortion. Sweden's sex education program was developed to prevent teenage pregnancy and abortion at the time of changes in Sweden's abortion law.

The U.S. has higher abortion rates among teenagers than other Western countries have teenage births and abortions combined. In 1985, the most recent national data indicate there were 800 abortions for every 1000 live births to women ages 15 to 19 and more abortions than births for girls under 15.

The Situation in Georgia

Georgia has one of the highest rates of teenage pregnancy in the U.S. In 1987 we had 30,650 pregnancies among teens (third highest in the nation), terminating in 17,000 live births, 8,400 legal abortions, and 5,200 miscarriages. In 1987, 13.2% of Georgia's 15-19 year old women were pregnant, 7% gave birth, 4.4% had an abortion, and 1.8% a miscarriage. This teenage childbearing has huge financial and societal costs.

The Southern Governor's Association lists Georgia as spending $355 million annually on only three programs: Medicaid, AFDC, and Food Stamps on families which began with a teenage pregnancy. If only these three programs are considered, single birth costs of a teen pregnancy are estimated at $11,600 the first year. Supporting this cohort of mothers and infants until the infant reaches maturity expends millions annually. Each year adds similar birth and long-term supports costs.

We need an aggressive program to decrease pregnancy among Georgia teenagers. If a large number of additional births are to occur in Georgia, additional large expenditures will be required.

The age of marriage in the U.S. has risen into the twenties; less than 7% of women and 2% of men are married in their teens. We all wish our teenagers would postpone sexual activity. There are those who believe sex and family life education should not be provided to children and teenagers, that this information causes experimentation and promiscuity, and that contraception increases abortion among teens. While polls show that less than 10% of the population believe this, they often control what information is available in public school. Teenage women face the dilemma: if they are sexually responsible and use contraception, they are "planning to be bad."

In the overall population in Georgia in 1987, there were 102,500 live births and 36,430 abortions reported (35%); corrections for under reporting of abortion would increase this percentage. If we are to decrease abortion in Georgia, we will have to remarkably increase our birth control programs, since prohibition of sexual activity has not proved to be effective in reducing the incidence of unwanted pregnancy.

ProChoice vs. AntiChoice

Religious and personal feelings, together with the large number of induced abortions in the U.S., have resulted in a large antichoice movement and politicization of the issue of women choosing to terminate pregnancy. A frenzy of antiabortion demonstrations and one bombing have occurred in the Atlanta area. The recent Supreme Court decision in the *Webster* case has stimulated antichoice groups to urge their state legislatures to restrict or prohibit abortion, and Georgia's legislature will be urged to do so in January.

Some women believe much of the antiabortion movement is a conscious or unconscious method of controlling women's reproduction since if a woman cannot control pregnancy she cannot control her education, career, or life.

Abortions occur because of using no contraception, ignorance (e.g., among 10-to-14-year-old girls), contraceptive failure (about 10% of users), rape and incest, and for genetic indications.

Legal abortion is a safe procedure. The American College of Obstetricians and Gynecologists

Requiring genetic abortions to be completed by 20 weeks is punitive as most of these are wanted pregnancies, and these parents will attempt a future pregnancy.

Standards list first trimester abortion as an office procedure. Deaths due to legal abortion occur less than 1/100,000 abortions, deaths due to pregnancy and childbirth about 10/100,000, with an additional 9 or 10/100,000 for other causes during pregnancy. The Centers for Disease Control has reported that abortions carried out in a hospital are not safer than abortions carried out in a clinic or doctor's office. There were 6 deaths reported among approximately 1.6 million legal abortions in the U.S. (there were 140,000 deaths among Mexico's 1.5 million illegal abortions). Deaths due to illegal abortion were the most common cause of maternal mortality in many parts of the U.S. before 1973 when abortion became legal.

Believing that it is a woman's choice whether to carry a pregnancy to term rather than that of a politician's or other's right to prevent that choice does not make one proabortion. Obstetricians are familiar with the terrible problems their patients and families have with unplanned, unwanted pregnancy, pregnancy of a child 10 to 14, and the tragedy of pregnancies with congenital anomalies, intrauterine infections, and genetic defects.

Who shall decide which abortions are to be permitted?

Unless genetic indications for abortion remain legal, women carrying a fetus with a lethal or severe congenital anomaly — anencephalic baby (no head or brain, always fatal), Down's syndrome, heart anomalies, hydrocephaly, etc. will be forced to carry pregnancies with these congenital abnormalities and genetic diseases to term, and women and their families live with the consequences. It is difficult and sometimes impossible to get a genetic abortion completed by 20 weeks with amniocentesis at 14-17+ weeks, culture and report taking 2-3+ weeks, (longer if cells fail to grow). Requiring genetic abortions to be completed by 20 weeks is punitive as most of these are wanted pregnancies, and these parents will attempt a future pregnancy. A fetus with no head may be discovered late in pregnancy; must this woman carry to term by law?

Teenage children pregnant through incest often conceal pregnancy, and women carrying pregnancies the result of rape and incest will be forced to carry to term and give birth. Documentation of incest and rape are legal procedures which delay and prevent early abortion.

Women who are HIV infected have a 20-50% chance of giving birth to a baby who is HIV infected. The woman may not live long enough to care for the child, and the average cost of caring for an AIDS-infected baby before it dies is $100,000. Many such babies are abandoned because their mothers are drug addicts. Should this woman be denied an abortion?

If abortion becomes illegal in Georgia, those who can afford it will obtain abortions elsewhere. The poor, especially minorities and teenagers and the young, will be forced to carry a pregnancy. The poor will not have safe legal abortion available as they do not have money for travel and abortion fees and will resort to illegal abortion. Illegal abortion was the most common cause of maternal death at Grady Memorial Hospital before abortion became legal.

Public hospitals provide medical services to women who have no other source of medical care. Prohibiting public hospitals and physicians who work in them from providing abortions interferes with the practice of medicine and discriminates against the poor. Tax funds are spent for many things for which some taxpayers are opposed.

Some anti-abortion individuals believe the fertilized ovum is a person and would give legal "personhood" to the fertilized ovum. A fertilized ovum is not a pregnancy. Physicians do not consider a pregnancy is present until a fertilized ovum is implanted on the uterine wall. Fertilized ova do not usually implant or sexually active women would be pregnant at nearly each contraceptively unprotected menstrual cycle. Physicians differentiate a fertilized ovum and pregnancy. Abortion is not needed unless a pregnancy is present. Any contraceptive which prevents implantation is considered an abortifacient by some members of this group. Thus, birth control pills which make the uterine lining unsatisfactory for implantation, or intrauterine devices which irritate the uterine lining, in their view "cause" abortion. Our most effective contraceptives are therefore considered abortifacients — unacceptable to a large group of "anti-abortion" believers.

Pregnancy, abortion, and birth are intimate personal matters with which legislators, legislative decisions, state regulations, and laws do not deal well. Occupying the Georgia Legislature with the abortion controversy will be divisive. Who shall decide if a woman may terminate a pregnancy? Under what circumstances?

An aggressive, well funded birth control program for Georgia would be the best program to prevent unwanted pregnancies and resulting abortions. The Georgia abortion law should not be changed to prevent abortion in public hospitals for the poor or restricted to life or health of the mother in proven rape or incest. Few obstetricians are proabortion. Most believe that the patient and her family should have the right to choose whether or not to carry a pregnancy to term. ■

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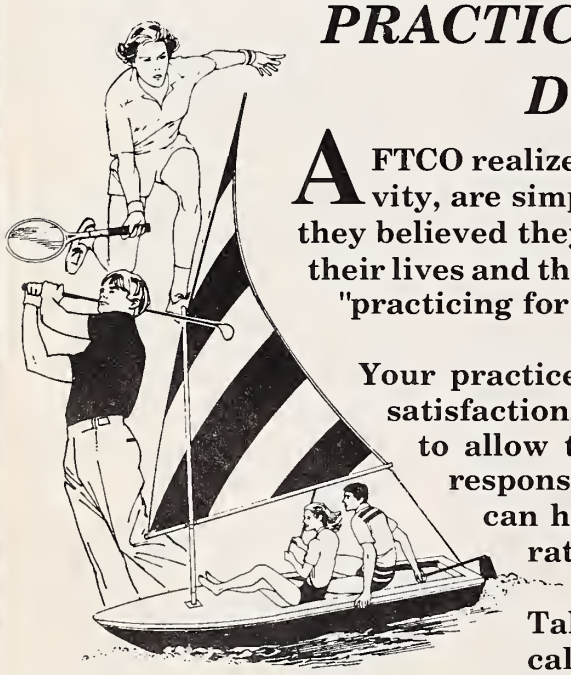

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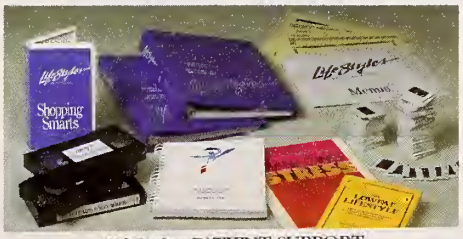

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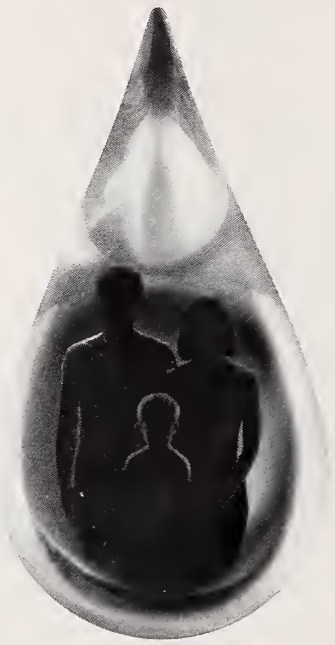

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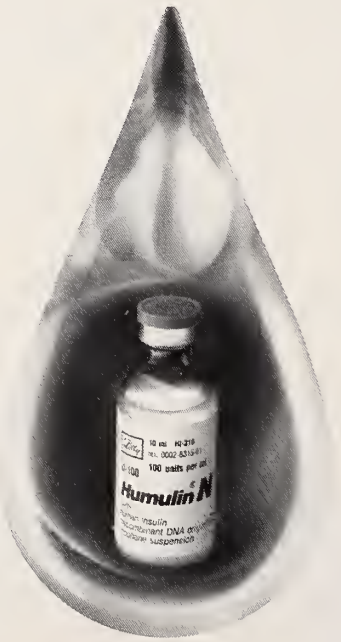

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Involuntary Smoking in Savannah's Restaurants

Robert S. Wilson, M.D.

Abstract

A survey of Savannah area restaurants was conducted to determine the frequency with which nonsmoking sections are provided. Only one in five restaurants in Savannah provide nonsmoking sections, and only one in 10 tables available for dining out are reserved for nonsmokers. Restaurants associated with a national corporation are more than four times as likely to reserve space for nonsmokers than those strictly locally owned. Pertinent attitudes of restaurant personnel are presented, as is a brief discussion of the issue of involuntary smoking.

Methods

A TOTAL NUMBER OF 304 restaurants were identified via the March, 1989, Savannah Southern Bell Yellow Pages. Representatives from each of these were contacted by telephone between April and June of 1989, and each (100%) indicated whether or not their place of business provides a nonsmoking area. Those from 301 of the 304 (99.0%) took the time to answer additional survey questions as well. 32.2% of respondents were restaurant owners, while 67.8% were either managers, assistant managers, district managers, or area supervisors.

Results

A total of 62 (20.4%) of the 304 restaurants contacted provide nonsmoking sections for their patrons, while 242 (79.6%) do not (Table 1). Restaurants with nonsmoking sections on average reserve 36.0% of their tables for nonsmokers. Of an estimated city-wide total of 8,833 tables available for dining out, only 944 (10.7%) are reserved for nonsmokers (Table 2).

Approximately half (49.5%) of respondents from restaurants without nonsmoking sections indicated that their primary reason for not providing this service is a lack of adequate space in their dining rooms. Twenty-seven percent indicated a lack of demand by their patrons; 13% stated that the decision was not up to them.

Dr. Wilson recently completed his residency in Family Practice at Memorial Medical Center in Savannah. Send reprint requests to him at 122 Harmon Creek Dr., Savannah, GA 31406.

On the other hand, a little more than half (51%) of those representing restaurants which do provide nonsmoking sections indicated that their primary reason for doing so is in fact demand from their patrons. Twenty-six percent said this is a requirement of the chain or franchise of which they are part; 12.0% noted the business advantage that such a service offers them.

While 61.5% of representatives from restaurants without nonsmoking sections feared that initiating this service would make it very difficult to seat customers promptly, 89.8% of those with nonsmoking sections already in operation disagreed that this is a problem.

When presented with the observation that the smell of cigarette smoke may make the meal of a nonsmoker less pleasant, 89.8% of those representing restaurants with nonsmoking sections agreed, as did 83.5% of those from eating places without nonsmoking sections. A to-

Table 1. Percent of Savannah Restaurants Providing Nonsmoking Sections

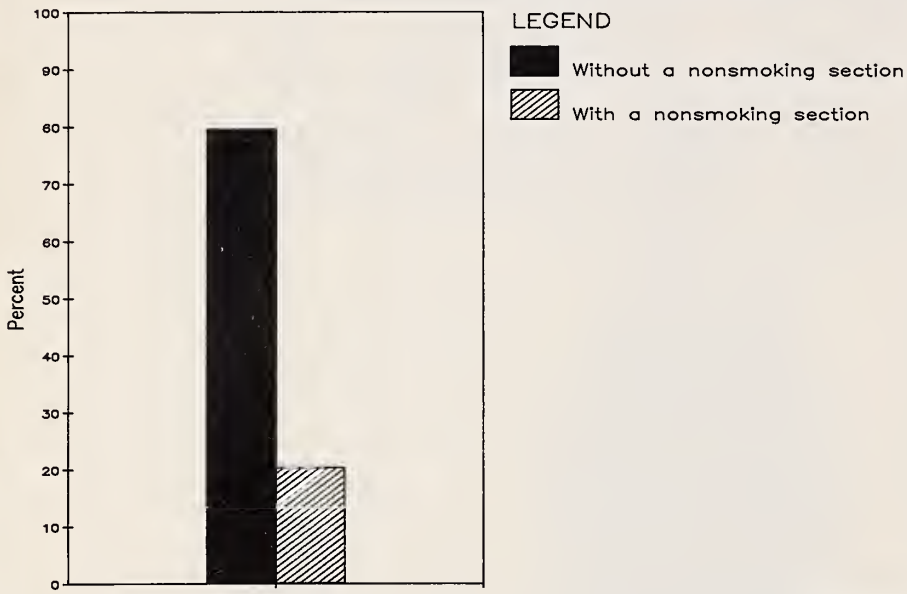
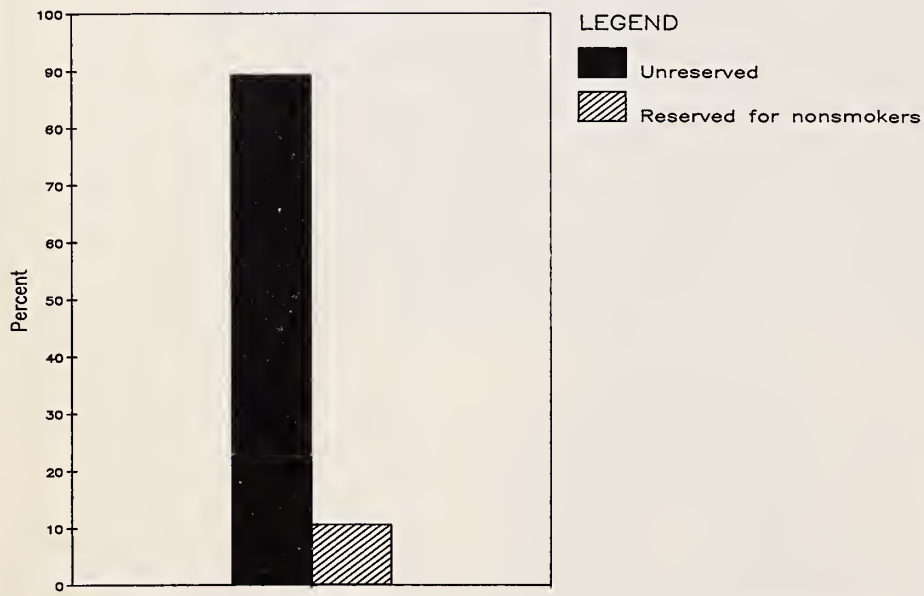


Table 2. Percent of Total Savannah Tables Reserved for Nonsmokers



tal of 91.8% of those with nonsmoking sections also agreed that it is unhealthy for nonsmokers to breathe in cigarette smoke, as did 81.0% of those without nonsmoking sections.

While 98.0% of those with nonsmoking sections agreed that providing this service is good for their business, only 42.0% of those without felt that introducing this service would be good for business. Almost 90% of those with a nonsmoking section agreed that there is a significant public desire for nonsmoking sections in restaurants, but only 66.0% of those without agreed with this same statement.

A total of 37.6% of those restaurants that are part of a national company provide nonsmoking sections locally, as do 21.4% of those part of a southeastern company. On the other hand, only 8.9% of those restaurants not associated with a national or a southeastern corporation provide nonsmoking sections (Table 3).

Discussion

Assuming that Savannah's smoking incidence does not greatly exceed that of the U.S. or of Georgia, which by 1987 had decreased respectively to 29%[1] and 25%,[2] the results of this survey demonstrate that far too few tables in Savannah are reserved for nonsmokers. It is ironic to note that in a city so well-known for excellent dining, 90% of tables are catered to the bad habits (or addictions) of a minority of people, and only one in 10 is reserved for the majority who do not smoke.

In light of recent concern about the health effects of involuntary smoking, this disparity between the high percentage of nonsmokers and the low number of tables reserved for them is disturbing. Although the degree to which individual nonsmokers are annoyed by the smell of burning tobacco varies, well documented acute irritative symptoms include itchy eyes, sneezing, sore throat, headache, and cough.[3] However, irritated mucous membranes and individual levels of annoyance are not the only issues at hand, as mounting evidence indicates that involuntary smoking causes serious health problems.[4-7]

Cigarette smoke contains thousands of chemicals, including 43 known carcinogens[1] and poisons such as arsenic, cyanide, and carbon monoxide. Urinary levels of the nicotine metabolite cotinine correlate well with reported exposure to tobacco smoke in nonsmokers.[8,9] It has been clearly shown that chronic exposure to to-

bacco smoke at home and in the workplace results in a higher incidence of lung cancer in nonsmoking adults and that children exposed to smoke in the home have more frequent respiratory illnesses

Only one in ten Savannah restaurant tables is reserved for the majority who do not smoke.

and some impairment in rates of lung maturation.[6]

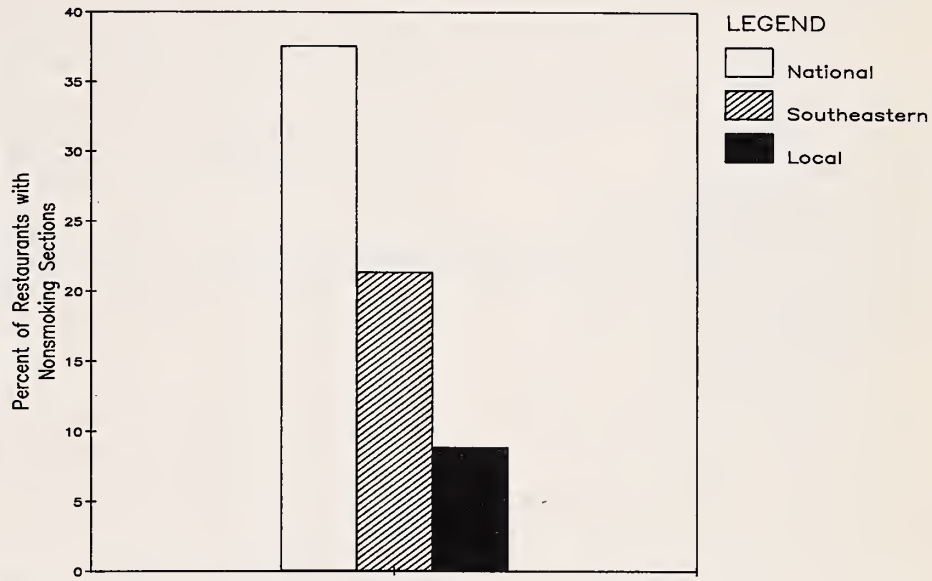
Furthermore, there is in addition to lung cancer a long list of other diseases associated with active smoking, including coronary artery and cerebrovascular disease, chronic bronchitis and emphysema, and cancers of the mouth, throat, bladder, and kidney,[3] and it is not yet known to what extent these impact passive smokers as well.

Additional research is necessary to determine the significance of involuntary smoking outside of the home or workplace, for instance in public places such as restaurants, where the toxins in the smoke are the same but the frequency of exposure presumably less.

In the meantime, however, experts within the World Health Organization,[10] the National Academy of Sciences,[7] and the office of the U.S. Surgeon General[1,6] agree that involuntary smoking poses a significant risk to health and that measures to protect nonsmokers are in order. The American Cancer Society[11] and American Lung Association[12] have also endorsed the right of the nonsmoker to be free from breathing tobacco smoke in enclosed public places.

The present survey shows that most Savannah restaurants do not provide separate seating for smokers, most often because of limited space or a perception that

Table 3. Effect of Association with a National or Southeastern Corporation on Provision of a Nonsmoking Section



their nonsmoking patrons are not bothered by environmental tobacco smoke. Those not providing nonsmoking sections generally feel that doing so would unduly complicate their seating arrangements, and they are skeptical about whether or not nonsmoking sections are good for business.

In contrast, those providing nonsmoking sections are clearly convinced that this service is pleasing to a majority of customers, is good for business, and does not produce significant problems in getting patrons seated. Excerpts of these results have been sent to restaurants participating in the survey in hopes that those without space reserved for nonsmokers will learn from the favorable experiences of those with separate smoking sections in place.

It is encouraging that almost all respondents were sensitive to the fact that involuntary smoking is both unhealthy and unpleasant for nonsmokers, though representatives of restaurants with nonsmoking sections were more frequently cognizant of this.

A few respondents without nonsmoking sections argued that sectioning off part of their dining room would not really solve the problem because of the mixture of air throughout the room by the ventilation system. Certainly separate dining rooms and ventilation systems are the ideal alternative, but these are not always available or economically feasible.

An arbitrary line separating smokers and nonsmokers does at least allow for dilution of the dangerous and unpleasant smokers' fumes, giving some degree of protection to nonsmokers. The only other alternative may be the total banning of cigarette smoking in all enclosed public places, and this has in fact been legislated in certain U.S. municipalities. Unfortunately, such legislation has often been sighted as an infringement on smoker's rights.

Legislative Recourse

Although Savannah's restaurants were the subject of this survey, all enclosed public places must somehow accommodate both smokers

and nonsmokers. In recent years, numerous U.S. city, county, and state governments have adopted ordinances protecting the rights of their citizens to clean indoor air, including New York City, San Francisco, New Orleans, and well over 400 others.[13] The finding that Savannah restaurants under the influence of a national corporation are more than four times as likely to provide a nonsmoking section than those under local influence alone attests to this national trend toward higher clean indoor air standards.

Readers are forewarned that as efforts get underway in Savannah and other communities in Georgia to pass strong clean indoor air ordinances, the tobacco lobby in our state may mount a formidable response.

Although several counties in Georgia do restrict smoking in publicly owned buildings,[14] there is no such law in Chatham County, and in Savannah there is no law requiring separate smoking and nonsmoking areas in public places. This study shows that voluntarily imposed smoking restrictions in the city's restaurants have resulted in only 10% of tables being reserved for nonsmokers, despite their majority status. Apparently legislation will be necessary to protect the city's nonsmoking citizens.

The response of the tobacco industry to local efforts for such legislation in other states has been via professional, well-financed lobbyists, usually working at the state level.[13] The result in more than one state has been suspiciously weak state laws restricting smoking which pre-empt all local ordinances, thus crippling efforts for meaningful clean indoor air legislation at the city and county levels (where the tobacco industry is typically less influential). This strategy has been successful for the pro-tobacco lobby despite surveys showing that a majority of smokers in fact favor separate smoking areas in public buildings and in the workplace.[15]

Currently, the only Georgia State law pertinent to involuntary smoking simply prohibits smoking in public elevators, transportation vehicles, and other areas that are clearly designated with a no-smoking sign, violators being subject to a fine of $10 to $100.[14] Readers are forwarned that as efforts get underway in Savannah and other communities in Georgia to pass strong clean indoor air ordinances, the tobacco lobby in our own state may mount a formidable response. Such ordinances are needed, however, because without them the rights of smokers all to often interfere with the nonsmoker's right to breathe clean indoor air.

Whether legislative action on the issue of involuntary smoking in Georgia occurs at the local or state levels or both, it should include the banning of cigarette smoking in all enclosed public places and work places, such as retail stores, airports, offices, factories, hotel lobbies and restaurants, except in clearly designated smoking areas. Ordinances in most cities across the United States have been lenient on smaller businesses, for example not requiring a restaurant seating fewer than 50 people to provide a separate area for smokers or a grocery store employing fewer than 15 people to provide a separate breakroom for nonsmoking employees.

Responsibility for enforcement of ordinances protecting non-smokers has typically been given to local public health officials. As a practical matter, however, these laws are self enforcing. A predominantly nonsmoking public has grown tired of breathing tobacco smoke while waiting in line at the grocery store, spending a routine day at the office, or trying to enjoy a nice meal out. Strong legislation is all that is needed to equip that frustrated, health-conscious public to protect itself.

Acknowledgments

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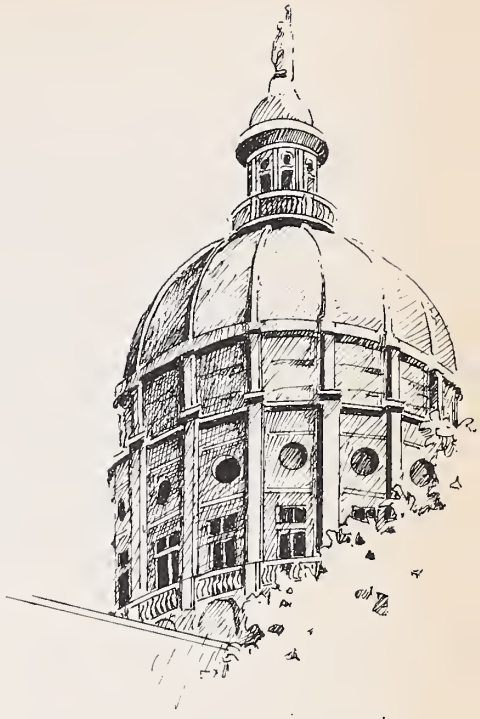
Highlights of Legislation Before the 1990 Georgia General Assembly



Paul Shanor, Richard L. Greene

ONE THING that can be predicted accurately for the 1990 Georgia General Assembly — it will be interesting. Politics will take center stage as Georgia gets ready to elect a new Governor for the first time in 8 years, and a new Lt. Governor for the first time in 16 years. Add the abortion issue created by the U.S. Supreme Court in its 1989 decision of Webster v. Reproductive Health Services as well as another tight fiscal year (due in part to increased health costs), and this should be a Session to please all who favor chaos over order.

As part of this interesting scenario, several from the Senate leadership are vying against each other, making activities in that Chamber particularly intriguing. Lt. Governor Zell Miller is opposing Senator Roy Barnes for Governor. The President Pro Tem of the Senate, Senator Joe Kennedy, is facing the Chairman of the Senate Human Resources Committee, Senator Pierre Howard; Senator Bud Stumbaugh, Chairman of the Senate Insurance Committee; and Senator Wayne Garner, Chairman of the Senate Corrections Committees in crowded bid for Lt. Governor. In the House of Representatives, Lauren "Bubba" McDonald (supported by Speaker Murphy) is running for Governor, while Jim Pannel of Savannah is running for Lt. Governor.

Against this competitive backdrop, there are important medical issues facing the General Assembly. Some of these are pending from last year, and some of them will be new in 1990.

Pending 1989 Legislation

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Legislation was introduced at the end of 1989 in order to spur debate — and hopefully reach consensus — on some tort reform for obstetricians. We have received almost unanimous support for some type of tort bill, but developing an acceptable approach has been difficult. MAG Staff has worked closely with both state and national experts as well as legislative leaders to develop a responsible and responsive bill.

Medicaid/Medicare Assignment as a Condition of Licensure

Representative George Brown of Augusta introduced a bill last year that would require all physicians in Georgia to treat any Medicaid or Medicare patient as a condition of licensure (Senator Al Scott of Savannah also had similar legislation). Since those payments sometimes do not cover overhead, it means that he wants some doctors to practice medicine for a negative income! Last year we beat back these efforts to deny physicians control over their patient mix, and we will need everyone's help again this year.

Mandatory Continuing Education for Physicians

Introduced by Representative George Green, M.D., at the request of the George Academy of Family

Mr. Shanor is MAG's Executive Director and Mr. Greene is MAG's General Counsel.

Physicians, MAG supported the version that passed the House. The bill required 40 hours biennially of approved continuing medical education but kept record keeping to a minimum and made it a disciplinary action, not a condition of licensure for those who failed to comply. The bill died last year due to Sen. Al Scott's amendment to require Medicaid and Medicare acceptance as a condition of licensure, but a "clean" version (without amendments) should pass this year.

Durable Power of Attorney for Health Care Decisions

Rep. Jim Martin introduced a bill calling for a durable power of attorney to be made available specifically for health care decisions. While Georgia presently has a durable power of attorney available for certain financial and real estate decisions, the statute lacks an original legislative intent to cover health care decisions when a principal becomes incompetent.

This bill supplements the "living will" statute in that it is available for non-terminal as well as terminal illnesses. The agent is explicitly authorized to accept to refuse treatment on behalf of the principal. This legal authority obviates the need for judicial intervention in all but a few situations where the principal's course of treatment is in question. MAG will be working with Rep. Martin and representatives from the Georgia Hospital Association and the Fiduciary Law Section of the State Bar to come up with appropriate language for this bill.

Regulations of Tanning Parlors

Representative Nan Orrock, at the request of MAG, introduced legislation establishing some regulations over the so-called tanning parlors. This legislation is a direct result of the efforts of the Georgia Society of Dermatologists who brought the issue to the MAG Legislative Council where it gained MAG support. There is a good chance of this legislation passing in 1990. Although there has been no vote, a favorable response is expected from the legislators, as evidenced by their support at the informal committee hearing on the subject held during the special Session last September.

Review of the Medical Examiners System

Last year Rep. Billy Randall introduced a resolution at MAG's request to study the medical examiner system. At the request of the Chairman of the Rules Committee, MAG agreed to let the House Health & Ecology Committee be the study committee. Several concrete legislative changes will be introduced as a result of this study that will increase quality and establish for the first time a true medical examiner system in Georgia.

Independent Practices by Physical Therapists

Representatives John Simpson, Eleanor Richardson, and Nan Orrock introduced this legislation that would have allowed physical therapists to treat patients without ever consulting with a physician. This bill would have given them more power to practice than a chiropractor. Suffice it to say that the chiropractors joined MAG in opposing this bill. The bill was held in the House Health & Ecology Committee. It has been vigorously lobbied by the physical therapists in the interim and during the Special Session held last September 11-15, 1989. This issue involves all physicians in that it is another unacceptable infringement of the Medical Practice Act.

Potential Legislation in 1990

Revision of pension laws to protect pension income from garnishment or other legal attachment

While there is present a statute protecting the corpus of a pension from attachment, the protection does not extend to the pension income as it is paid out in installments to a physician. Attorneys may presently file a continuing garnishment against a doctor's pension income to satisfy a malpractice judgement. We have had numerous requests for this type of legislation and intend to introduce an appropriate bill this session.

Multi-copy Prescription

A strong potential exists for the introduction of a triple-copy prescription bill to the 1990 General Assembly with strong support from the Attorney General's office, the Drug Enforcement Agency, and the Georgia Bureau of Investigation. Such an issue has attractive publicity potential for law enforcement, and we can expect a high profile legislative initiative. The MAG Legislative Council's opinion is that, while a problem with prescription abuse certainly exists in Georgia, the multi-copy script requirement will do little to address the problem while placing a tremendous burden on physicians and patients alike.

Labeling to better identify prescribed medication

The MAG Legislative Council was directed by the 1989 House of Delegates to work toward passage of legislation during the 1990 Session that would require "labeling on all prescriptions dispensed to non-hospitalized patients showing the generic name and the brand name when a brand name drug is substituted with a generic drug as follows: *Generic name* substituted for *Trade name* as in '*Furosemide* substituted for *Lasix*.' " MAG will be introducing the bill this upcoming Session.

Lab Privileges for Chiropractors

The chiropractors will probably be introducing legislation during the 1990 Session seeking the right to lab privileges in all hospitals and perhaps lab facilities, generally. We have not seen any drafts of such a proposal at the time of this writing but are following it as appropriate. (Also, see reference to chiropractors below in worker's compensation proposal. They also are proposing a major rewrite of their practice act, once again attempting to expand their scope of practice.)

Worker's Compensation

A new worker's compensation package has been introduced to address the considerable complaints by business and trial lawyers as to alleged excessive fees charged for certain physician services, over-utilization of certain procedures, cost of providing medical records, and access to prior test results. Additionally, the bill will cover medical records sought by chiropractors, as well as an attempt to bring chiropractors under the statutory definition of "Family Physicians."

The bill also contains some components providing for expanded benefits for injured employees and limits on benefits for temporarily permanently disabled employees.

Speech-language Pathologist & Audiologists

The Georgia Academy of Family Physicians may be introducing legislation to delete language requiring a physician to be on the premises when hearing tests are conducted by non-physicians (O.C.G.A. 43-44-7). Prior to a 1986 amendment, persons conducting audiology tests needed only to be under the supervision of a physician. "On the premises" language was added as a compromise. The present language poses a potential problem for DHR in that public health screenings are often conducted without a doctor on the premises.

AIDS

A bill will be introduced this session to allow HIV testing without first notifying the patient beyond a general consent to treatment. This would put HIV testing in the same category as any other disease treatment.

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A Five-year Retrospective Study of Admissions to a Trauma Center in Southeast Georgia

Diane G. Bowen, M.D., Carl R. Boyd, M.D., F.A.S.C., W. Cooler, J. S. Williams, M.D., F.A.C.S.

Abstract

A five-year retrospective review of a computerized trauma registry at Memorial Medical Center, Inc. (MMC), the designated Level I Trauma Center of Region IX EMS, was accomplished to identify patterns of epidemiology and use of our regional trauma center. All trauma admissions from 1983 through 1987 were reviewed with respect to mechanism of injury, age, gender, outcome, mode of prehospital transport, and referral source. Seventy-five percent of 4862 admissions were due to blunt trauma. Sixty percent were brought directly to the trauma center; 40% were interhospital transfers from outside the local area. The average length of stay was 12 days. Retrospective review of trauma registry data is helpful in determining the use and quality of care of a regional trauma center.

Introduction

TRAUMA CARE in the Southeast area of Georgia was reorganized in 1983. Memorial Medical Center became the designated Level I Trauma Center for Emergency Medical Services (EMS) Region IX. At that time, a computerized trauma registry was implemented to organize and standardize data collection so that analysis of needs, resources, and outcome would be available for internal review and intercenter comparison.[1-3] The Trauma Registry data for a 5-year period was used to identify regional epidemiologic patterns and critically assess patient outcome with respect to nationally accepted standards of trauma care.

Materials and Methods

The chart of each trauma patient admitted to MMC was reviewed following hospital discharge for data concerning demographics, prehospital transport and care, admission, resuscitation, surgical intervention, procedures, complications, transfusions, rehabilitation, and discharge. Included in the review were all deaths in the emergency department or operating room, and all DOAs. Data were extracted from the chart by trauma nurse reviewers or the data coordinator, and then entered into the registry using an IBM-PC. The data for 4868 trauma patients entered into the registry between January, 1983, and December, 1987, were reviewed for epidemiologic information, regional referral and transport patterns, and analysis of quality assurance efforts.

Memorial Medical Center (MMC), Inc., located in Savannah, Georgia, with a population greater than 200,000 is the Level I Trauma Center of Region IX EMS. MMC serves 24 primarily rural counties, encompassing 12,000 square miles and a population of over 600,000. Addition of a hospital-based helicopter service in July of 1985 saw an expansion of MMC's service area to 43 countries, encompassing over 1,000,000 population and 80 referring facilities and extending into South Carolina and northern Florida. The city lies at the junction of two interstate highways, one of which is the major north-south corridor on the Atlantic coast. Transportation to the trauma center by ground ranges from thirty minutes

Send reprint requests to Dr. Bowen at Memorial Medical Center, P.O. Box 23089, Savannah, GA 31403-3089.

TABLE 1 — Blunt and Penetrating Trauma, Level I Trauma Center for Emergency Medical Services (EMS) Regional IX, Savannah, 1983-1987

	Total #	Blunt #	Trauma %	Penetrating #	Trauma %
1983	682	464	68	218	32
1984	738	545	74	193	26
1985	775	609	79	166	21
1986	960	754	79	206	21
1987	996	780	78	216	22
TOTAL	4,151	3,152		999	

TABLE 2 — Types of Trauma, by Age Groups, Level I Trauma Center for EMS Region IX, Savannah, 1983-1987

	Total #	0-14 Y.O	15-35 Y.O	36-55 Y.O	>55 Y.O
Auto Accident	1,277	8%	58%	19%	15%
Gunshot Wound	663	6%	65%	22%	6%
Stab Wound	336	2%	73%	21%	4%
Assault	340	11%	55%	26%	7%
Motorcycle Accident	273	14%	71%	12%	2%
Burn	209	40%	37%	11%	12%
Fall	884	30%	25%	19%	26%
Pedestrian	378	46%	30%	11%	12%
Other	508				
Total	4,868	17%	54%	18%	11%

TABLE 3 — Type of Admission, Level I Trauma Center for EMS Region IX, Savannah, 1983-1987

Admissions		Direct #	Direct %	Transfer #	Transfer %
1983	787	598	76	189	24
1984	864	637	74	227	26
1985	954	704	74	250	26
1986	1,129	771	68	358	32
1987	1,134	803	71	331	29
TOTAL	4,868	3,513		1,355	

from neighboring countries to three hours from outlying areas of the region.

Results

Epidemiology

Mechanism of Injury. A total of 4151 patients were reviewed to determine the mechanism of injury (Table 1). Excluded were burns and other injuries, such as snakebite, which did not fit into blunt or penetrating trauma classification. The observed trend was toward an increasing percent of blunt trauma. Total trauma admissions increased by 46% since 1983, while admissions for blunt injuries increased by 68%.

Age. Eighty percent of those admitted for trauma to MMC were 45 years or younger (Table 2).[4] Burns and pedestrian accidents occurred more frequently in the 0-14-year-old-age group, while those 15-35 years of age were more likely to be involved in auto accidents, motorcycle accidents, assaults, gunshot wounds, and stabbings. Falls showed a slight predilection for the younger and older ends of the age spectrum.

Gender and Race. Males were preferentially targeted by all forms of trauma by a two to one margin over females. Caucasians were much more likely to be involved in blunt trauma (auto accidents, motorcycle accidents, and falls), while non-caucasians were more often victims of penetrating injuries (gunshot and stab wounds). Burns, pedestrian accidents, and assaults demonstrated no significant racial preference.

Regional Referral and Transport Patterns

During the study period, trauma admissions to MMC from outside Region IX increased fourfold. The greatest increase (155%) was realized in 1985, with the inception of MMC's hospital-based emergency air medical service. A second observed trend was a decrease in the percent of patients admitted from within Chatham County, in contrast to Region IX admissions from outside Chatham County and outside the region (Figure 1).

The percent of trauma patients transferred from other facilities showed a modest increase, most significantly since 1985 (Table 3). Patients admitted to MMC from referring facilities had injuries of increasing severity over the study period as evidenced by injury severity scoring data. One-quarter of trauma patients admitted in 1983 had an Injury Severity Score (ISS) of 15 or greater.[5] By 1987, that fraction had grown to one-third. The magnitude of this change is realized when examined from a different perspective. Admissions with ISS scores less than 15 increased by 37% over the 5-year study period, while those with ISS scores of 15 or greater increased by 93%.

ICU admissions for trauma have increased by 85% since 1983 (Table 4). Sixty-nine percent of trauma patients transported by helicopter and 29% of those transported by ground

ambulance were admitted to intensive care units (Table 5).

Quality Assurance

Survival for the 4868 trauma patients was reviewed with respect to Trauma Score (TS) and Injury Severity Score (ISS). The TS of 737 patients admitted in 1983,[6] and 1032 patients in 1987,[7] were available for review. These survival curves (Figures 2 and 3) are similar to the curve generated by the Major Trauma Outcome Study (MTOS) data on more than 24,000 patients.[8] ISS scores were available for 4820 patients admitted between 1983 and 1987, and their survival compared favorably to the MTOS patients (Figure 4).

A total of 297 deaths occurred in the 4868 trauma admissions, for an overall mortality of 6%. Exclusion of patients brain dead on admission (DOA) results in a decrease of approximately 2% in reviewable mortality.

Shortly after designation as a Level I trauma center, county and regional prehospital treatment protocols were developed. Using data extractors, the need for and use of oxygen, IVs, endotracheal intubation, cervical spine control, and MAS trousers in the field was objectively determined. For trauma victims directly admitted from the field, compliance with treatment protocols increased from 50-80% to at least 90% in all areas.

Discussion

Initially, MMC admitted less than 800 injured patients annually. In the ensuing 5 years, the numbers grew to almost 50% of the original figure, with a parallel growth in resources to receive and care for the growing volume of trauma victims. Growth was originally projected to be roughly 10% per year, which proved to be accurate until 1985, when MMC's regional emergency response capability expanded to include a hospital-based and staffed air ambulance service. Since then an increase in trauma admissions from outside Region IX EMS has occurred, with a concomitant decrease in the percent of in county

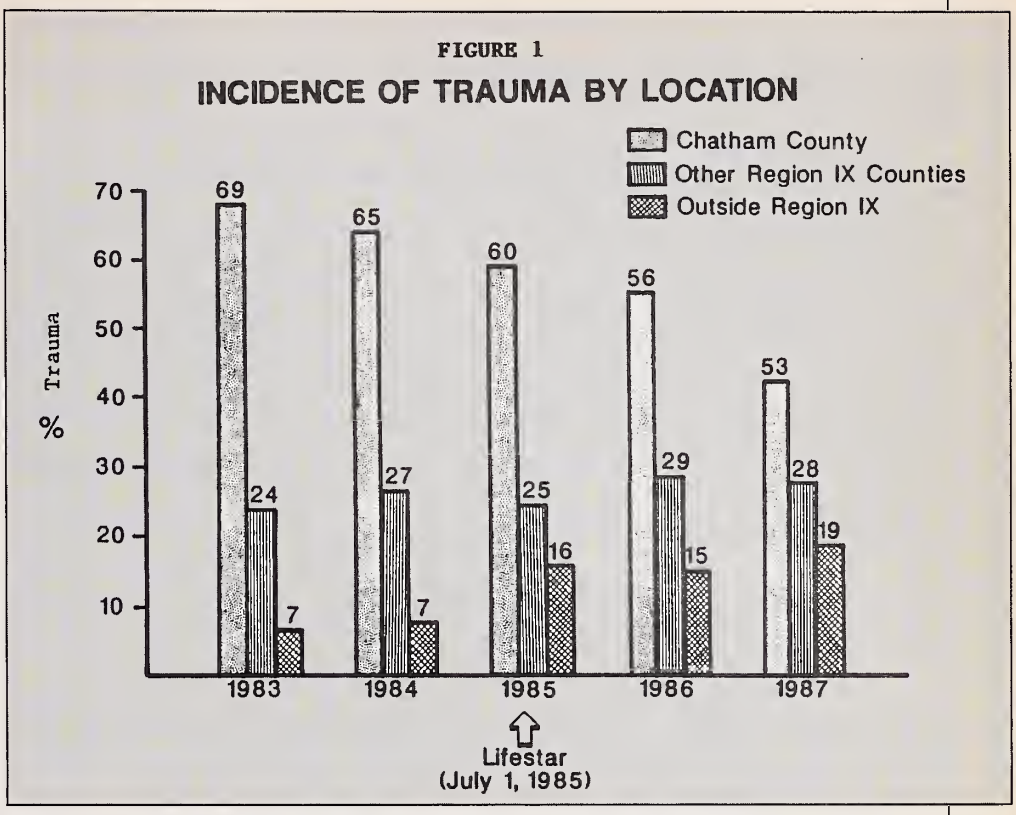

Figure 1. Trauma by County of Origin, Level I Trauma Center for EMS Region IX, Savannah, 1983-1987.

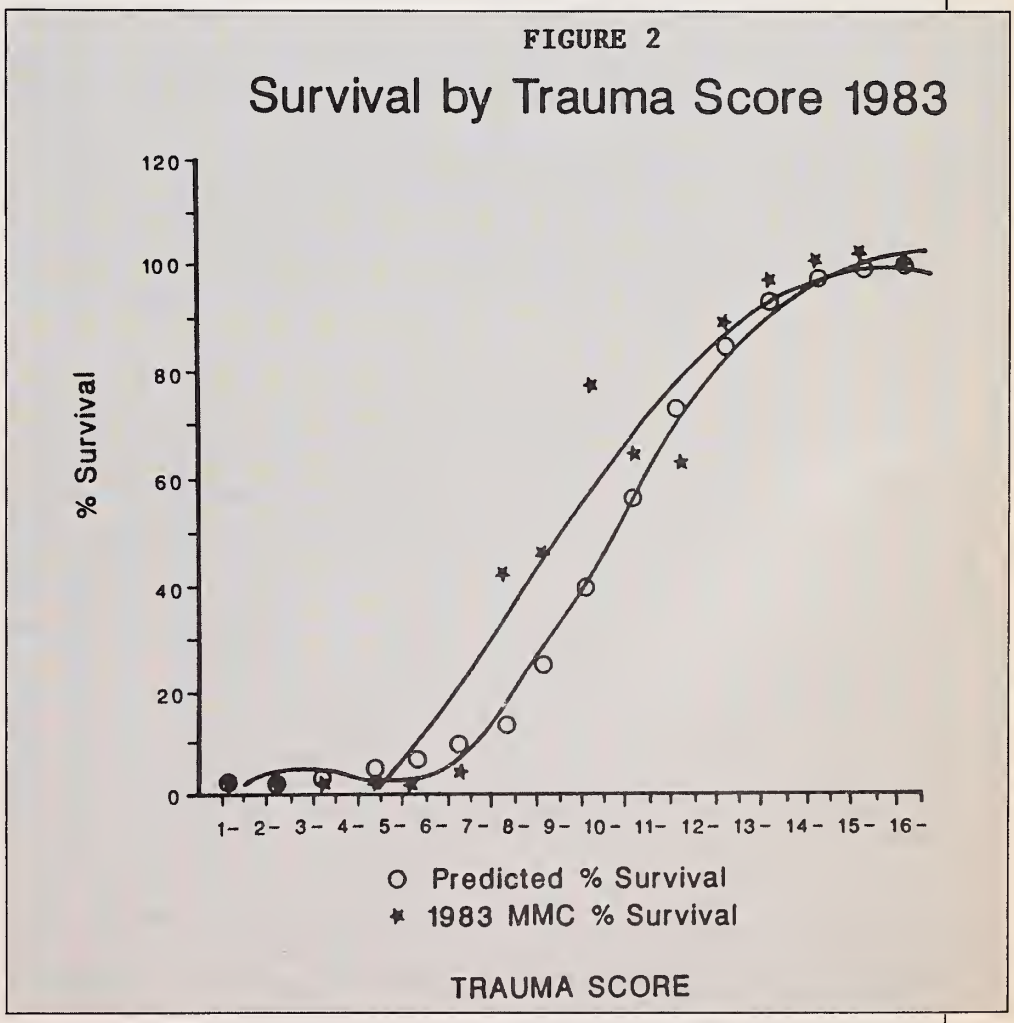

Figure 2. 1983 Survival by Trauma Score — MTOS and MMC, Level I Trauma Center for EMS Region IX, Savannah, 1983-1987.[6]

FIGURE 3

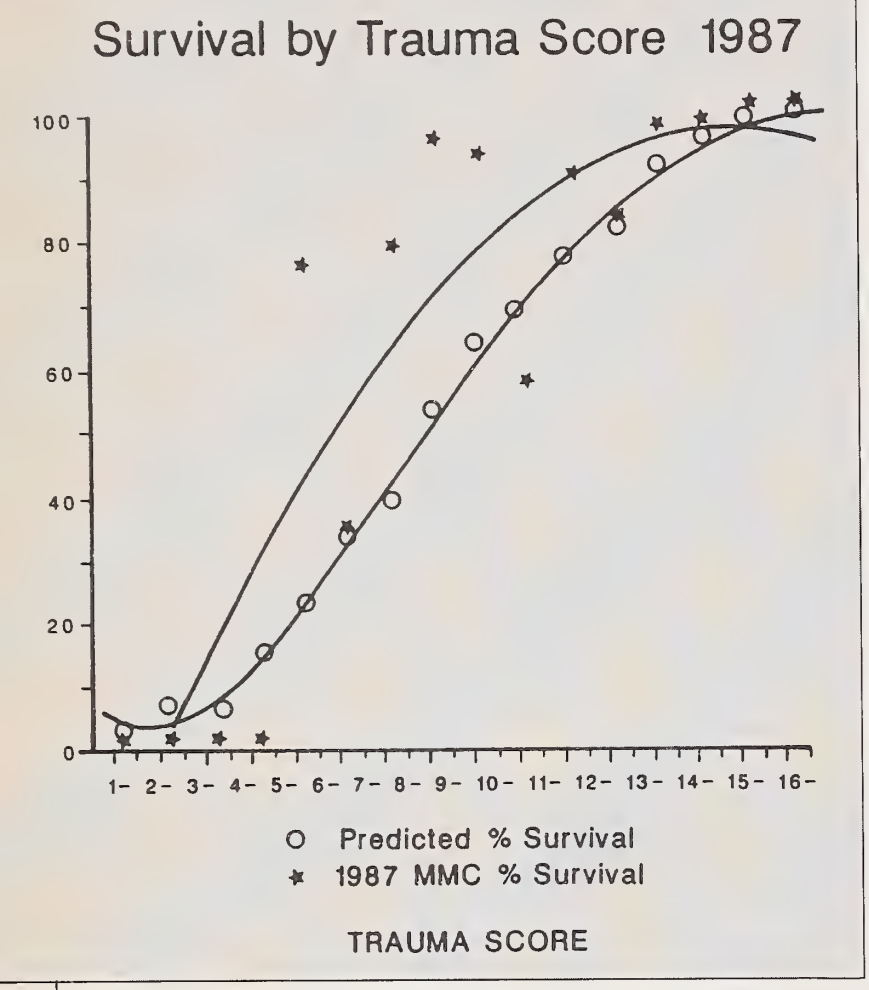

Figure 3. 1987 Survival by Trauma Score — MTOS and MMC, Level I Trauma Center for EMS Region IX, Savannah, 1983-1987.[7]

TABLE 4 — Unit of Admission, Level I Trauma Cente for EMS Region IX, Savannah, 1983-1987.

	Total	*ICU*	*Floor*
1983	787	184	603
1984	864	203	661
1985	954	255	699
1986	1,129	302	827
1987	1,134	341	793
TOTAL	4,868	1,285	3,583

TABLE 5 — Type of Transport, Level I Trauma Cente for EMS Region IX, Savannah, 1983-1987

	Total	*Helicopter*	*Ground*	*Private Vehicle*
ICU	1,285	249	927	109
Floor	3,559	111	2,301	1,147
Morgue	24			
TOTAL	4,868	360	3,228	1,265

admissions. Currently, injuries of increasing severity account for a greater percent of trauma seen, increasing total length of hospitalization for trauma patients. Perhaps the factor of change with the greatest impact on use of resources was the air transport services, with 69% of all helicopter transported trauma patients requiring ICU admission.

Analysis of trauma registry data has allowed for planning and allocation of resources, such as personnel, facilities, equipment, and educational programs. Through bimonthly Quality Assurance meetings, deficiencies and needs in these areas are determined, and plans outlined to address each.

The trauma center has responded to the growing demands documented by the trauma registry data for transport, triage, and intensive care resources. The hospital-based helicopter program established in 1985 has decreased travel time by one-half to one-third.[9] MMC emergency department is currently expanding to three times its present capacity, and recent additions have increased ICU facilities. Personnel resources are also being expanded in response to greater demands. The full-time faculty has been doubled and will continue to grow as needed. Regular assessment of Quality Assurance had allowed for constant redefinition of direction and maintenance of a dynamic and progressive trauma service.

Probability of survival was calculated for each patient using the TRISS methodology, derived from the TS, ISS, age, and mechanisms of injury. Outcome assessment was accomplished by reviewing those patients highlighted by TRISS as diverging from their expected outcomes. The American College of Surgeons Committee on Trauma has outlined in its Hospital Resources Document the essential elements of a quality assurance program in any level I trauma facility.[10] They include a morbidity and mortality review, review of cases which fall out by audit filter examination, a multidisciplinary trauma committee, a review of prehospital and regional systems of trauma care, and maintenance of a trauma registry which contains relevant and accurate prehospital patient data. The MMC registry has been designed to facilitate the first four elements listed above. Using data generated by the trauma registry, internal review is conducted by a multidisci-

plinary committee to provide quality assurance and to improve the center's response to major trauma.

The Trauma Center has grown both in volume and maturity since the initiation of the trauma registry. A pressing goal from the outset was education of prehospital personnel to standardize delivery of optimal field care throughout Region IX EMS. Use of the trauma registry in conjunction with regional dissemination of prehospital treatment protocols has been effective in identifying deficiencies and focusing on educational needs. This strategy has resulted in progressively increased compliance with protocols, approaching the target of 100% for in county transports by hospital-based and county emergency medical services.

There was a 93% increase in admissions with injury severity scores of 15 or greater.

Beginning in 1989, the Georgia Department of Human Resources has supplied all state designed trauma centers with a computerized trauma registry, using dBase III plus, offering for the first time a means of compiling statewide data to assist in determining patterns of injury and quality of care. Input of injury detail by ICD-9 coding results in automatic computation of ISS, using the ICD-9-CM/AIS Conversion Table code developed by Johns Hopkins University, the Association for the Advancement of Automotive Medicine, and the Maryland Institute for Emergency Medical Services System. Audit filters are integrated into the program, allowing records requiring Quality Assurance review to be printed in a monthly report. Additionally, the registry format is compatible with MTOS data collection and automatically enters our trauma admissions into the Washington study.

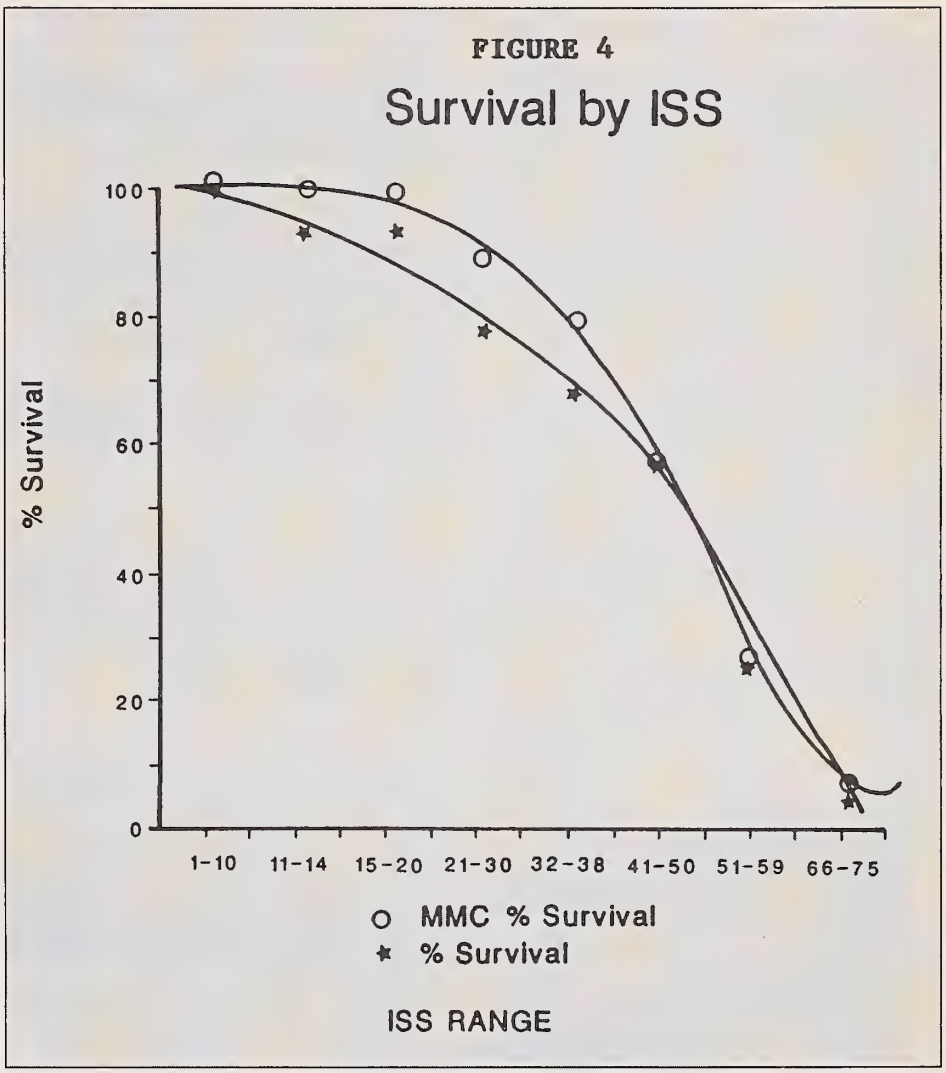

Figure 4. Survival by ISS Range — MMC and MTOS.

Summary

A total of 4868 trauma patients were admitted to MMC during the 5-year study period. On average, blunt trauma accounted for three fourths of trauma admissions. The trauma center has seen a 10% increase in blunt trauma over the study period. A majority of trauma patients were less than 45 years old. Males are involved in trauma twice as often as females.

Since the advent of the air transport service in July of 1985, admissions from outside Region IX EMS have doubled. Sixty-nine percent of air transported trauma patients require ICU admission. Also, the trauma center has seen an increase in injury severity, with a 93% increase in admissions with ISS scores 15 or greater. In response, both ICU and Emergency Department facilities have been expanded.

Analysis of trauma registry data has allowed for planning and allocation of resources, such as personnel, facilities, equipment, and educational programs.

A review of outcome using ISS and TS survival curves show overall survival rates for level of injury that exceed national standards. Overall mortality was 6%. This is decreased to 4% with the exclusion of DOAs.

The trauma registry has served to document increased compliance with prehospital treatment protocols. It is also the basis for evaluation of regional trauma epidemiology and allows for intercenter comparison and objective quality assurance programs. The designation of Level I trauma center requires institutional commitment, allocation of resources, and dedication of personnel. The capability of tracking epidemiologic trends, regional referral patterns, and transport characteristics has been invaluable in understanding and responding to both regional and in house trauma care needs. The commitment to become a designated trauma center is a commitment to accept and perform according to the highest standard of care.

The capability of tracking epidemiologic trends, regional referral patterns, and transport characteristics has been invaluable in understanding and responding to both regional and in house trauma care needs.

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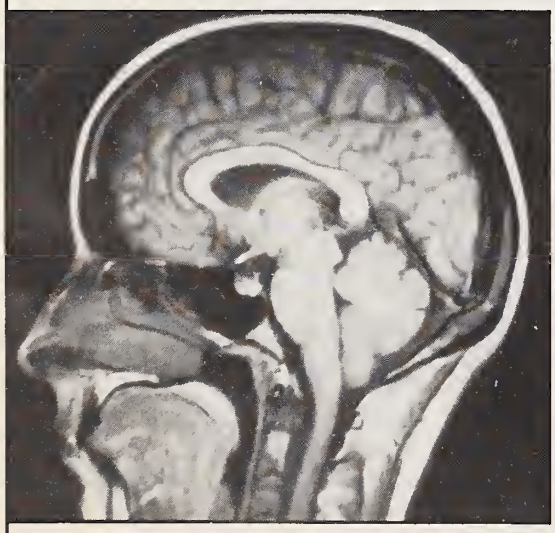
STROKE RECOVERY



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How Does a Traditional Chinese Physician Treat a Patient?

Part II of a Series

Charles B. Gillespie, M.D.

[Author's note: Much of what is included in this article was gathered from a number of sources about Traditional Chinese Medicine as it is interpreted even today. Many of the phrases used are extracted from research material for emphasis.]

THE FUNDAMENTAL principle of diagnosis in the Traditional Chinese Medical system is to analyze the symptoms of the sick before drawing conclusions and prescribing treatment. In practice, detailed questions are asked about the history of the illness. Attention is paid to the quality of the voice and the color of the face. The patient's pulse is examined and its characteristics carefully recorded (rate, regularity, etc.). On the basis of all these examinations, a "set of principles in medical treatment is made." The following are a few of those principles as quoted from Chinese medical literature: "symptomatic treatment in acute conditions and radical treatment in chronic conditions" and "prevention is more important than treatment." Traditional Chinese physicians have believed these principles to be most effective for thousands of years.

Traditional Chinese Medicine focuses on the essence of diseases. The surface sign and root cause of the disease must be distinguished.

Dr. Gillespie is an orthopedic surgeon. He visited China in May of 1989 at the time of the student demonstrations. This is the second in a series about the Traditional Chinese and Western Styles of medical care. Part I appear in the December, 1989, issue of the *Journal*.
Send reprint requests to him at 810 Fourteenth Avenue, Albany, GA 31708.

These same Traditional physicians have studied the "relationship between man and nature" as they are taught to believe that the function of the human body is, at every moment, affected by nature. Their philosophy is that the "human body is an organic whole with five internal organs (heart, liver, spleen, lungs, kidneys) as its center which are all related by 'channels' and affect each other pathologically. The failure of an internal organ will reveal itself in an outer organ, and the failure of an outer organ will affect an internal organ." They also study the relationship between the spirit and the body. Irritation and depression will affect the normal physical function of the body as illustrated in the following quotations from the well known medical text *Nei Jing:* "anger harms liver," "thinking harms spleen," "worry harms lungs," and "fear harms kidney."

Symptoms refer to all clinical manifestations, since disease is an indication of a contradiction between "vital energy" and "evil energy" within the body. Vital energy refers to the ability to resist diseases, while evil energy refers to the factors that incur illness. When evil

energy attacks the body, vital energy will respond to resist the attack, thus giving the physician "indications" that a disease is about to strike.

In traditional medical circles, there are eight principles in the general method of analyzing symptoms. Those eight principles refer specifically to eight kinds of syndromes. They are: *yin yang*, external, internal, hot, cold, insufficient, and excessive. In addition, symptoms can also be analyzed according to the state of vital energy, blood, body fluid, viscera, and other indications. All these methods are different in nature and are used in different situations, but they are all associated with each other.

The *yang* symptom is treated with inhibition; *yin*, with excitation; external, with diaphoresis; internal, with a laxative remedy; hot, with an antipyretic remedy; cold, with warning remedy; excessive, with a laxative remedy; insufficient, with a tonic remedy. However, most physicians believe that symptoms are not usually simple in that they interweave. "Sometimes it could be excessive on the surface, but actually insufficient, or the other way around." Consequently, compound treatment is likely to be adopted.

In word, Traditional Chinese Medicine focuses on the essence of diseases. The surface sign and the root cause of the disease must be distinguished. Each physician should abide by principles but also be flexible. "Medical measures are taken according to time, place, and the patient" by using dynamic observation techniques. Whereas Western Medicine focuses on the analysis of the specific disease itself, or pathogeny, Traditional Chinese Medicine reflects the principle that diseases are general in nature. "The individuality of disease is the key principle," and external causes are focused on in every instance. (Author's note: In the middle of one paragraph which stressed the importance of traditional medicine principles, the following sentence appeared: "As time and science advance, Chinese medicine and Western medicine will combine and complement each other.")

In one paragraph of a Chinese medical text, the following sentence appeared: "As time and science advance, Chinese medicine and Western medicine will combine and complement each other."

A wide variety of medicines are used in Traditional Chinese hospital and clinics, most of which are herbs and woody plants. They can be divided roughly into four categories in terms of their property: cold, hot, warm, and cool. Materia medica of warm and hot properties can dispel cold, whereas those of cold and cool properties can exterminate internal heat.

To treat "complicated disease," various herbs are often put together for the cure. A "recipe" for a specific disease can consist of the following categories of herbs which are assembled in order of importance and function. "Monarch medicines" are those that cure the patient; "minister medicines" assist the monarch medicines; "assistant medicines" treat minor symptoms and reduce and suppress the side effects of monarch medicines; "guide medicines" adjust properties of the other there medicines. Each physician knows full well that the "monarch medicines" are always indispensable, whereas the need for the other three types depends on the condition of the patient.

Chinese *Materia Medica* includes decoction, pulvis, pills, and extracts. To make a decoction, the patient mixes several medicinal herbs, adds water, and simmers the solution on a stove, then pours out the water and leaves the dregs. Decoctions are usually taken orally but sometimes are used to bathe the patient. Many other formulas are used, but one of the most interesting is that described to treat "underdevelopment of breasts" which states: "the development of the breasts is affected by heredity, the state of nutrition, and any underlying organic disease such as anemia, stomach upset, or gynecological problems. To promote a better development of the breast, the physician should use an animal placenta and female hormones (the use of a pig's placenta was strongly recommended). It should be stewed with chicken or a young pigeon or can be ground to become a pill. It should be taken two or three times a day with meat soup and/or other nourishing foods."

As the reader can surmise, Traditional Chinese Medicine does not "simply control pathogenetic microorganisms but regulates the chaotic functioning of the organism's environment and controls pathologic change." It "supports the health energy and strengthens the body resistance by promoting blood circulation to remove blood stasis." Thus, with these principles in mind, the Traditional Chinese Physician (as expressed by government sources) "plays a major part in the care of the more than one billion citizens of the People's Republic in China."

The next article will cover the subject: "Surgery in China Today and Tommorrow."

Retirement of a Surgeon

Part II: Economic Planning

Construct a lifetime blueprint and adjust your investments as conditions change. Coordinate your holdings in order to provide for active retirement, possible disability, and eventual demise.

When facing retirement, most Americans never seem to think that they have quite enough money. Doctors are no exception to this unsettling mind set. In order to provide some financial peace of mind, I will pass on several facts and impressions which were helpful to me.

The general attitude should be to consult professionals; however, set your own goals and make your own financial decisions. With this in mind, construct a lifetime blueprint and adjust your investments as conditions change. Coordinate your holdings in order to provide for active retirement, possible disability, and eventual demise. Enjoy the game of family protection, and be thankful for your worldly goods as well as your spiritual guidance.

Some personal observations about various aids to financial security are in order. These ideas are neither meant to be applicable to everyone, nor are they complete.

Insurance

Insurance has two basic advantages. It provides for tax-deferred money, and protects us and our families in the events of disability and death. At age 30, term life insurance and disability insurance are important. At age 45, universal life insurance and disability insurance are useful. At age 60, annuities are helpful. Between the ages of 65 and 70, loans from your insurance (including single premium variable life) can augment your income without nullifying your social security benefits. If you plan on retiring before age 65, and you intend to slowly phase out of your practice, you can go "bare" on your malpractice insurance and protect yourself against the large tail. (Three years before you drop the liability coverage, establish a living revocable trust which encompasses all personal assets of you and your spouse.)

(Part I: Freedom and Happiness appeared in the December, 1989, issue of the Journal.)

Trusts

Trusts are basically either revocable or irrevocable. One concept is to think of your trust as if it is another person. A revocable trust during your lifetime does not save taxes, but it allows you and your spouse to inventory your property, establish some immunity to confiscation, and can simplify your will while avoiding probate. An irrevocable trust can be used to isolate income-producing assets and pay some proceeds to your spouse and children (such as tuition) while reducing the size of your taxable estate.

One caveat is to name your loved ones as co-trustees to the trust, with the authority to change banks if they are not happy with the original institution. Everyone should probably include a bypass trust provision in his or her will. This will allow one to shelter 1.2 million dollars to his or her children. Indeed, some people (who are worth over $1.2 million) are establishing charitable

trusts for their pet projects. They can arrange to get a tax deduction for the gift and can get income from the earnings, while helping a good cause.

Investments

Investments are most effective when they can compound either tax deferred or tax free growth. The most popular methods are compounding through retirement plans, insurance accounts, and municipal bonds. A no load mutual fund account which allows telephone switching in and out of various funds has resulted in enviable retirement results. By using a 39-week stock and bond average, one can embrace safety, growth, and income. For example, a 40-year-old doctor with 100,000 dollars in 1980 would have over 600,000 dollars in his or her account today.

As previously stated, a personal insurance plan can give tax-deferred growth while providing protection to a family. Georgia municipal bonds provide immediate tax-free income which can be used now or accumulated for future use. If you have municipal bonds in your irrevocable trust, the interest can be passed through to the recipients completely tax free.

The idea is to balance your *total* wealth through diversification, adaptability, and compounding. The traditional investment pyramid should consist of a base of safety (bonds, annuities, certificates of deposit) progressing up (blue chip stocks and convertible bonds) to a speculative top (emerging small capital stocks). For the total projection, the magic number is 72. If your portfolio is returning a yield of 9%, it will double every 8 years. By this formula, you can determine now many years it will take for you to reach your desired goal, which is usually to retire with benefits equal to your current income.

Real Estate

Real estate is usually pretty well understood by everyone. I will only say that one day when the kids are gone, your dream house will be too large for two. If you can find a place with a good rental income, you can deduct the depreciation, plus up to $25,000 in cost. Your net worth can increase while you prepare for the smaller retirement home. If you sell your present home, you can get up to $125,000 in profit, tax free.

To avoid commercialization, I have not listed the services which have been of help to me. Personally, it was a fascinating hobby to relax from an exhausting practice and check the vital signs of my portfolio. I hope that you will derive some pleasure and benefit from this colleague's experiences. My best wishes to you, my fellow physicians, for a full and fruitful life, which is blessed by the goodness of God.

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The Constitutional Right to Abortion

Robert N. Berg

THE LEGAL STATUS of a woman's right to an abortion is currently a most widely discussed topic, one that can be found on the front pages of newspapers throughout the country, and heard on nightly network and local news telecasts, on virtually a daily basis. "Pro-choice" and "Pro-life" demonstrations are occurring throughout the United States. State governments (such as the Florida Legislature) have been called into special session, to debate the need for and scope of legislation supporting or curtailing a woman's right to an abortion; elections are being decided by a candidate's stance on the issue, and election results are being dissected and analyzed, as well as hailed or criticized, in terms of the potential impact on future abortion legislation. In reflection of the magnitude and importance of this topic, this issue of the *Journal* is devoted to various aspects of the abortion controversy — and, in this Legal Page, we try to provide some basic questions and answers concerning the current state of the law in Georgia and the possibility of changes in the future.

Does a woman have a Constitutional right to abortion?

Yes, at least for the present. In the seminal decision of *Roe v. Wade*,[1] a seven-member majority of the United States Supreme Court found that a woman's decision whether or not to terminate her pregnancy was a "fundamental Constitutional right," which could only be curtailed by a compelling State interest. The Court went on to identify two such possible State interests — the interest in protecting the health of the mother and the interest in protecting "the potentiality of human life" (i.e., the protection of viable fetuses). The Court stated, however, that these interests could not justify the State's regulation of abortions during the first trimester of pregnancy, beyond the State's merely requiring that the abortion be performed by a physician. As to the regulation of pregnancies during the second and third trimesters, the Court found that the State could regulate abortions in a manner reasonably necessary, in appropriate circumstances, for the preservation of the life or health of the mother and/or fetus.[2]

This article provides some basic questions and answers concerning the current state of the law in Georgia and the possibility of changes in the future regarding a woman's right to obtain an abortion.

Over the 15 years subsequent to the *Roe* decision (1973-1988), the Supreme Court dealt with the issue of abortion on numerous occasions. In virtually every case, the Court refused to narrow its holding in the *Roe* case, instead choosing to strike down a wide variety of attempted restrictions on the basic constitutional right to abortion.[3] The only real exception to this trend involved a series of findings by the Court that the U.S. Government, by statute, could refuse to fund abortions through the Medicaid program. The Court based its findings on the fact that, while a government could not place significant hurdles in the way of a woman's ability to obtain an abortion, the government could refuse to provide affirmative government aid (i.e., allocate public funds or resources) to assist the woman in obtaining an abortion.[4]

But didn't the U.S. Supreme Court recently eviscerate the right to abortion?

Although the U.S. Supreme Court in practice may have

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signaled "the beginning of the end" of a woman's Constitutional right to an abortion, the Court's decision in *Webster v. Reproductive Health Services,*[5] on its face, did *not* overrule the Court's prior decision in *Roe v. Wade*. Rather, read literally, the *Webster* case simply decided the following points:

a. The Court held that the preamble to a Missouri statute which set forth the time at which life begins (at conception) was not an impermissible restriction upon abortions. Rather, it was simply a "value judgment" of the State of Missouri that it favored childbirth over abortion. In the Court's view, until such time as the State attempted to use the preamble in order to restrict abortions or other aspects of medical practice, the preamble, standing alone, was not unconstitutional.

b. The Court also upheld a Missouri statute which prohibited public funds, public facilities, and public employees of Missouri to assist in the performance of non-therapeutic abortions. The Court reasoned, similar to its previous decisions upholding the Hyde Amendment, that it was permissible for a State to express a political preference for childbirth rather than abortion, and to support that preference by refusing affirmatively to assist in the performance of abortions, through the provision of public facilities, employees, or funds.

c. Finally, the Court found that the Missouri legislature could provide a rebuttable presumption of viability at 20 weeks and that physicians, to the extent necessary, conduct certain viability tests, prior to performing second trimester abortions. The Court viewed this as no more than a means of safeguarding important State interests which came into being after a fetus became viable.[6]

"As far as the potential for changes in this statutory scheme in Georgia, much obviously will depend upon the U.S. Supreme Court's upcoming decision in the three abortion cases."

The importance of the *Webster* decision, and the basis for expecting significant future restrictions on a woman's Constitutional right to abortion, arose out of the fact that, although they disagree somewhat on the specific Constitutional underpinnings, a five-member majority of the Supreme Court now appears willing to overrule the Court's earlier decision in *Roe v. Wade* and its entire "trimester" analysis. Of these five justices, three (Justices Rehnquist, White, and Kennedy) have expressed in no uncertain terms their belief that the *Roe* trimester analytical framework is "unsound in principle and unworkable in practice,"[7] but were unwilling to use *Webster* as the vehicle for overruling *Roe;* a fourth Justice (Scalia) would have explicitly overruled *Roe;*[8] and the fifth, Justice O'Connor, while implying that *Roe* should be overruled, concurred that the *Webster* case was an inappropriate vehicle for doing so, and that there would be "time enough to reexamine *Roe* and to do so carefully."[9]

If the Supreme Court is to overrule Roe v. Wade, when will it do so?

Currently, there are three cases before the Court dealing with restrictive State abortion statutes, and it is expected that these cases may serve as the framework within which the Court will redefine, if not eliminate, a woman's Constitutional right to abortion. Two of the pending cases[10] deal with conflicting lower court rulings on the issue of a State's requirement of parental notice/waiting period. In one case, the U.S. Court of Appeals for the Eighth Circuit refused to invalidate a Minnesota statute which required both parents to consent to an abortion on an unemancipated minor, and also imposed a 48-hour waiting period. In the other case, the Sixth Circuit Court of Appeals struck down an Ohio statute which contained a 24-hour notice requirement and also required an unemancipated minor, seeking an abortion, to provide prior notice to at least one of her parents. In each case, the applicable statute contained a "judicial bypass procedure," pursuant to which the minor could seek court approval, in lieu of obtaining parental consent.

In the third case,[11] the Court of Appeals for the Seventh Circuit struck down several Illinois statutes imposing significant restrictions on abortions. One statute, for example, required clinics performing first and second trimester abortions to obtain a certificate of need and to comply with the Illinois Ambulatory Surgical Treatment Center Act, in essence requiring structural and physical plant standards similar to those of a hospital.

What is the anticipated effect of all of this on the Georgia abortion statutes?

Currently, abortions in Georgia are regulated under the Georgia Criminal Code, which provides that "a person commits the offense of criminal abortion when he administers any medicine, drugs, or other substance whatever to any woman or when he uses any instrument or other means whatever upon any woman with intent to produce a miscarriage or abortion," except in certain circumstances defined by statute.[12] A person convicted of the offense of criminal abortion may be punished by imprisonment for not less than 1 nor more than 10 years.[13] Moreover, a physician who performs, procures, or aids or abets in performing or procuring a criminal abortion may have his or her license to practice medicine suspended or revoked.[14]

The Georgia statute goes on to provide that it does not prohibit an abortion performed by a duly licensed physician, "based upon his best clinical judgment that an abortion is necessary."[15] However, after the first trimester, an abortion may only be performed in a licensed hospital or in a health facility licensed as an abortion facility by the Georgia Department of Human Resources;[16] an abortion may be performed after the second trimester only if the physician and two consulting physicians certify that the abortion is necessary in their best clinical judgment to preserve the life or health of the pregnant woman.[17] The statute also includes various reporting requirements, relating to physicians, hospitals, and other licensed health facilities.[18]

In all likelihood, Georgia's current abortion statutes would be unconstitutional under a strict *Roe v. Wade* standard. As far as the potential for changes in this statutory scheme, much obviously will depend upon the Supreme Court's upcoming decisions in the three abortion cases. Although the *Webster* decision earlier this year, standing alone, might conceivably support a movement to enact more restrictive abortion statutes in Georgia (or perhaps to eliminate entirely the right to obtain an abortion), it is far more likely that "pro-life" proponents will await what is expected to be more sweeping "pro-life" decisions by the Court during its 1990 term, as the foundation for developing more restrictive abortion regulation in Georgia. Whether the Supreme Court will act as expected in this area — and whether States such as Georgia will follow with more restrictive abortion controls (or, indeed, with statutes prohibiting abortions in total) — is something best left for a future Legal Page article.

Notes

1. 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973).
2. *Id.*, 410 U.S. at 161-165.
3. *See, e.g., Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976) (invalidating laws requiring spousal and parental consents to abortions); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 103 S.Ct. 2481, 76 L.Ed. 2d 687 (1983) (invalidating laws requiring 24-hour waiting period and hospital-only abortions after the first trimester); *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 106 S.Ct. 2169, 90 L.Ed. 2d 779 (1986) (invalidating reporting requirements).
4. *See, Harris v. McRae*, 448 U.S. 297, 100 S. Ct. 2671, 65 L.Ed. 2d 784 (1980) (upholding "Hyde Amendment" prohibition against use of Medicaid funds to reimburse the costs of abortions, except where the life of the mother would be endangered if the fetus were carried to term); *see, also, Maher v. Roe*, 432 U.S. 464, 97 S.Ct. 2376, 53 L.Ed. 2d 484 (1977); *Poelker v. Doe*, 432 U.S. 519, 97 S. Ct. 2391 (1977).
5. _____ U.S. _____, 109 S.Ct. 3040, _____ L.Ed. 2d _____ (July 3, 1989).
6. *Id.*, 109 S.Ct. at 3055-3061.
7. *Id.*, 109 S.Ct. at 3056-3058.
8. *Id.*, 109 S.Ct. at 3064.
9. *Id.*, 109 S.Ct. at 3061.
10. *Hodgeson v. State of Minnesota*, 853 F.2d 1452 (8th Cir. 1988), *cert. granted* 106 L.Ed.2d 587 (1989); *Akron Center for Reproductive Health v. Slaby*, 854 F.2d 852 (6th Cir. 1988), *prob. juris. not.* 106 L.Ed. 2d 586 (1989).
11. *Ragsdale v. Turnock*, 841 F.2d 1358 (7th Cir. 1988), *juris. post.* 106 L.Ed.2d 587 (1989).
12. O.C.G.A. §16-12-140(a).
13. O.C.G.A. §16-12-140(b).
14. O.C.G.A. §43-34-37(a) (8).
15. O.C.G.A. §16-12-141(a).
16. O.C.G.A. §16-12-141(b).
17. O.C.G.A. §16-12-141(c).
18. O.C.G.A. §16-12-141(d), 16-12-141.1.

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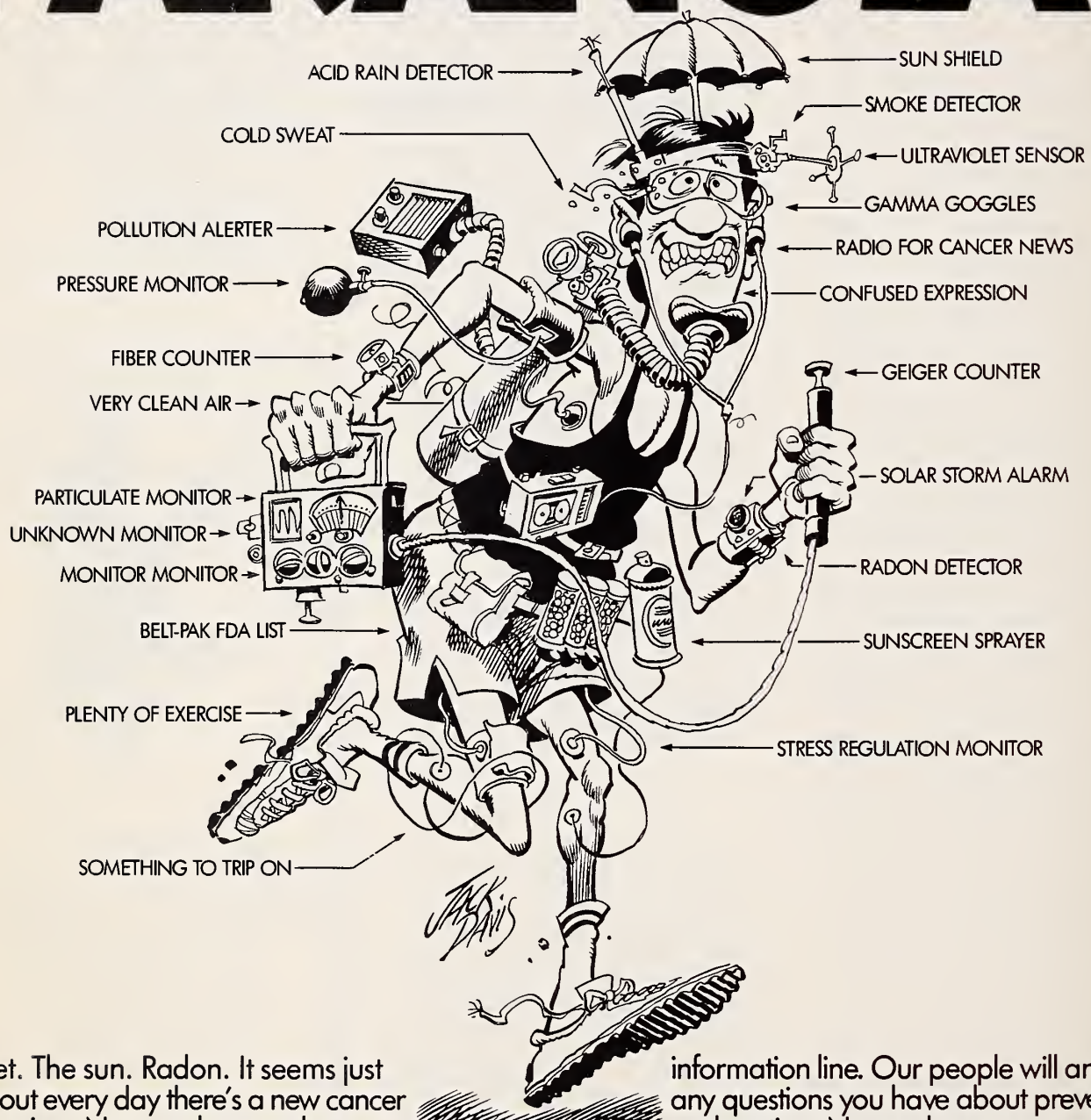

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> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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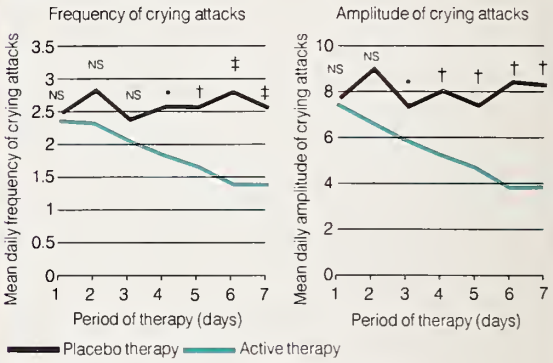

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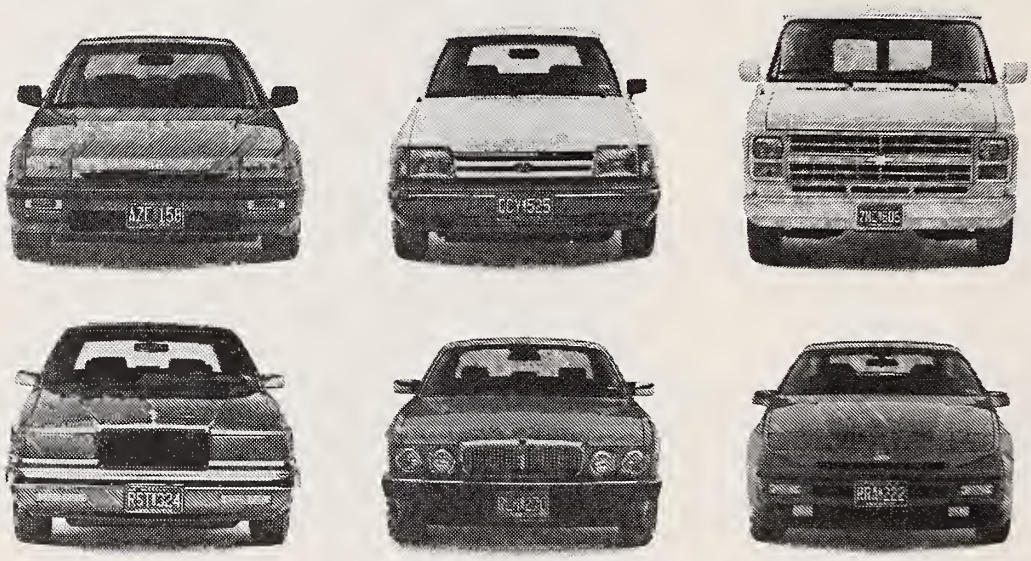

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THE COVER

"Partners in Health Care" is the theme of this special issue which focuses on the practice of nursing in these dynamically changing times.

Cover design by Pamela Joy Trow, of The Advertising Studio, Atlanta.

MRI UPDATE

Figure 1

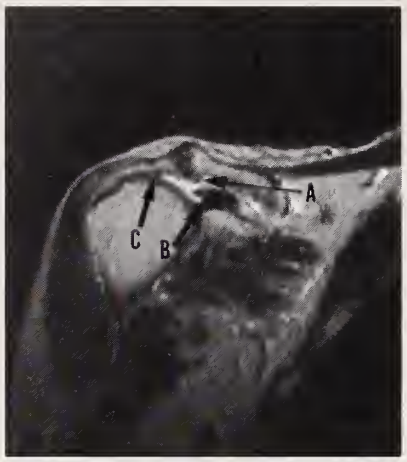

Figure 2

Figure 3

CLINICAL INFORMATION: This is a 69-year-old male who is unable to abduct his right arm and who has difficulty extending his arm. This is associated with right shoulder pain.

FINDINGS: Figure 1 is a proton density image in the coronal plane of the right shoulder. There is degenerative hypertrophy of the right acromioclavicular joint with a prominent inferior projecting osteophyte (A). A roughly linear area of low signal intensity inferior to the right distal clavicle represents the medial aspect of the rotator cuff (labeled B). A thin linear structure of low signal intensity superior to the right humeral head (labeled C) represents the lateral portion of the rotator cuff. Figure 2 is a T2-weighted image again demonstrating the inferior projecting osteophyte from the acromioclavicular joint (A) and the components of the torn rotator cuff (labeled B and C) as previously described. Increased signal intensity material between the torn portions of the rotator cuff represents joint fluid lying both within the joint space and in the subacromial bursa. Image #3 is a partial flip angle image which is sensitive for T2-weighting. This exhibits increased signal intensity in the immediate region of the rotator cuff tear as well as extending lateral over the right humeral head. The level of this slice is slightly anterior to figures 1 and 2 and the increased signal intensity material represents joint fluid extending over the right humeral head into the subdeltoid bursa.

The MR images demonstrate complete disruption of the rotator cuff which may be due to an acute injury or possibly due to chronic entrapment of the rotator cuff by the degenerated right acromioclavicular joint.

COMMENT: MR imaging is the only modality capable of directly visualizing and differentiating the various soft tissue components of the musculoskeletal system. Only CT arthrography approaches this degree of accuracy in the detection of rotator cuff tears, however CT arthrography like its cousin, routine shoulder arthrography, is invasive and requires injection of contrast into the shoulder joint. MR is the imaging modality of choice in the initial evaluation of soft tissue injuries of the shoulder joint with routine or CT arthrography reserved for those patients on whom the MR study was indeterminate.

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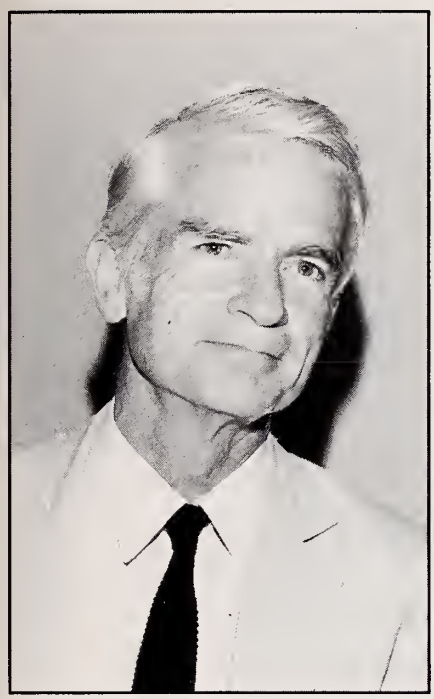

Joe L. Nettles, M.D.

The Lady With The Lamp

THE CALL from the hospital last night was not about the usual temperature elevation or the need for a sleeping pill. It had overtones of urgency. Mrs. Talbert, the charge nurse on orthopedics, just stated that she thought I should check Mr. Brown. I didn't ask her for his vital signs or just why she felt I should get up, dress, and drive eight miles to the hospital to check Mr. Brown. I just did it. I knew the charge nurse well enough to know that she understood when help was needed and would not ask me to come if she did not feel it necessary.

When I arrived at the hospital, the patient, who had undergone a hip replacement a week earlier, was apprehensive, and except for some minimal complaint of breathing difficulty, appeared stable. Blood gases and subsequent lung scan established the diagnosis of pulmonary embolus. Fortunately, early diagnosis and proper treatment averted a possible disaster. Ed Brown owed his life to the astute observation and discerning care of a dedicated nurse.

That episode dramatically illustrates the extent to which the medical profession depends on quality nursing care. Our hospitals, offices, and clinics could not function without good nurses.

Born in Florence, Italy, "The Lady with the Lamp," Florence Nightingale achieved lasting fame for her dedication to the injured in the Crimean War. Her noble image lends romance to one of the world's greatest professions. This romance is enhanced by the white uniform with the navy cloak and varied caps.

However, the true picture may be long hours of drudgery with little appreciation and poor pay. No wonder there is a nursing crisis. Young people can find easier ways to make more money, and many nursing schools are closing without an adequate supply of applicants. Many hospitals have been forced to curtail services. The projected outlook points to an increasing shortage of nurses.

The American Medical Association's experiment with registered care technologists is not working out. Efforts are being made to seek ways to enhance the entry of Licensed Practical Nurses and Nurse's Aids into Registered Nurses Training Programs. This may help, but will not be enough.

We must show the nursing profession proper respect and appreciation if we are to continue to be blessed by their support.

Joe Nettles

NEW MEMBERS

Beatty, Douglas C., Family Practice — Southwest Georgia — (Active) Corner Victoria & Church St., Blakely 31723.

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Sabsowitz, Fred, Pathology — MAA — (Active) 905 Wildwood Rd., Atlanta 30324

Smulian, John C., Obstetrics/Gynecology — Muscogee — (Active N2) 803 Overlook Dr., Columbus 31906

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Waters, William C. IV, Internal Medicine/Nephrology — MAA — (Active) 35 Collier Rd., Ste. 350, Atlanta 30309

PERSONALS

Bibb County Medical Society

Longtime Macon physician **W. Derrel Hazlehurst, M.D.,** has been recognized with the naming of an endowed scholarship in his honor at the Mercer University School of Medicine upon the occasion of his retirement from the practice of internal medicine in January, 1990.

Dr. Hazlehurst received his M.D. degree from Vanderbilt Medical School in 1938, and completed his internship and residency at Roper Hospital in Charleston, SC. He also received the M.S. degree in public health from Johns Hopkins in 1944. Hazlehurst is a Fellow in the American College of Physicians.

The scholarship will support deserving medical students pursuing the primary care specialty of internal medicine at Mercer. Individuals interested in more information about this endowed scholarship or who wish to participate in this scholarship may contact the Mercer University School of Medicine Development Office at 404-744-2715.

Georgia Medical Society

Fred I. Daniel, M.D., of Savannah, has become a Fellow of the American College of Surgeons.

Clayton-Fayette CMS

Jeffrey A. Kunkes, M.D., an otolaryngologist with South Atlanta Ear, Nose, and Throat in Riverdale, was recently elected president of the Georgia Society of Otolaryngology for 1990-1991. Dr. Kunkes is a board certified member of the American Academy of Otolaryngology Head and Neck Surgery as well as a member of American Academy of Facial Plastics Surgery.

Cobb CMS

Dan Bryan Stephens, M.D., an obstetrician and gynecologist from Marietta, has been elected chairman of the Obstetrics Section of the Southern Medical Association at its 83rd Annual Scientific Assembly recently held in Washington, D.C.

Dr. Stephens is past chief of Obstetrics and Gynecology at Kennestone Hospital in Marietta and past president of the Cobb County Medical Society. He currently serves on the Cobb County Board of Health and is vice-chairman of the Board of Trustees of the Medical Association of Georgia.

DeKalb CMS

O. Wytch Stubbs, Jr., M.D., Director of Medical Affairs at DeKalb Medical Center in Decatur, has been given the Emory University School of Medicine Alumni Association's Award of Honor in recognition of his long service to Emory and to the local community.

After receiving his divinity degree from Emory's Candler School of Theology in 1955, he began his career as a Methodist minister. In 1962, he resigned from active ministry to fulfill his dream of becoming a family physician. He received his M.D. degree from Emory University in 1966 and completed his internship at Georgia Baptist Medical Center.

In addition to his private practice, Dr. Stubbs serves on the clinical faculty at Emory. He has been president of the Emory

Medical Alumni Association and the Emory University International Alumni committee, and has been a University Trustee and member of the Board of Visitors.

Floyd-Polk-Chattooga CMS

Frank L. Hampton, M.D., of Rome, has been named a Diplomate of the American Board of Family Practice (ABFP).

Medical Association of Atlanta

Jerome M. Marchuk, M.D., of Riverdale, has recently been inducted as a Fellow in the American College of Surgeons.

Dr. Marchuk has been practicing medicine in the area since 1986. He is on the staffs at Clayton General and South Fulton Hospitals.

Dougherty CMS

James H. Stone, M.D., and **Joseph L. Jordan, M.D.,** both of Albany, have been recertified as diplomates of the American Board of Family Practice.

OTHER NEWS

Support Our Skelton

W. Douglas Skelton, M.D., Dean of Mercer University School of Medicine in Macon, is running for a seat on the AMA's Council on Scientific Affairs. Let's get a head start on improving his chances to win by writing to AMA delegates you know, telling them about Dr. Skelton and asking them to support his candidacy. The election is June, 1990, at the AMA House of Delegates. If MAG can assist you with addresses of AMA Delegates, please let us know. Call Donna Glass at MAG Headquarters.

First Juvenile Detention Center Accredited

The Atlanta Youth Development Center of Adamsville was recently accredited by MAG's Committee on Prison Health Care.

The accreditation is presented by the MAG Committee on Prison Health Care when a detention facility or prison meets a set of 60 standards of health care. "This is the first juvenile detention center in Georgia to come into compliance with these standards and become accredited by the MAG Committee on Prison Health Care," said Dorothy J. Parker, MAG staff person for that committee.

The program currently accredits health services at 27 prisons and jails. The major goal of the program is to improve the quality of health care provided to incarcerated persons, including juveniles. The 60 standards cover adequacy of medical, nursing and psychiatric coverage, sick call procedures, training issues, medical records and other related areas.

Meeting this set of standards requires a significant coordination of effort on the part of facilities who wish to work for accreditation. Accreditation is voluntary. At Atlanta YDC, a successful team effort over a period of six months or more on the part of administration, youth workers, and health staff led to this valued recognition.

According to Ann Strand, YDC Director, James Densler, M.D., a pediatrician, and Medical Director, Gail Mattox, M.D., child psychiatrist, and the Director of Nursing, Bertha Owens, R.N., all contributed to this achievement. Earlier this year, site visits were conducted by Bethanne Jenks, M.D., a pediatrician specializing in Adolescent Medicine, and Dorothy J. Parker of the Medical Association of Georgia. This first accreditation is for 1 year and can be renewed for 2-year intervals.

The clinic staff of the first youth detention center, the Atlanta Youth Development Center, to be acredited by MAG's Prison Health Care Committee. Shown left to right are James Densler, M.D., Gail Mattox, M.D., Charles Stewart, D.D.S., Bertha Owens, R.N., Linda Dudley, R.N., and Georgia Brown, R.N.

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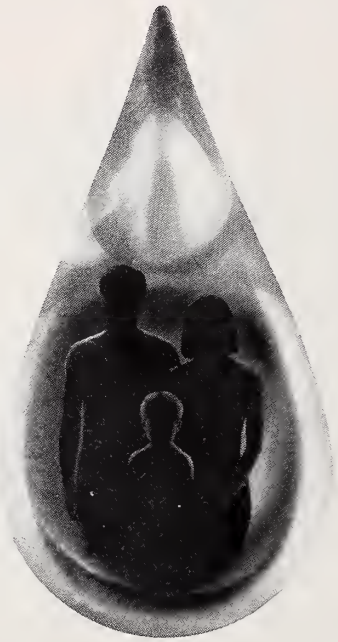

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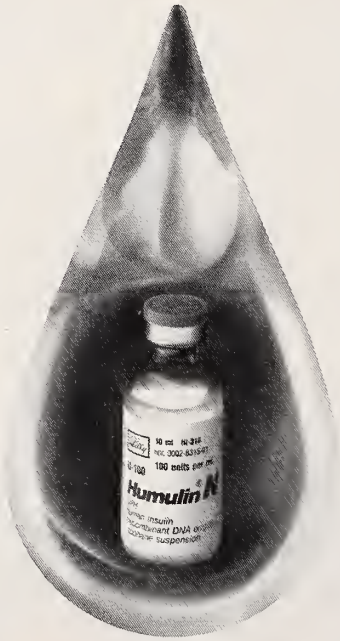

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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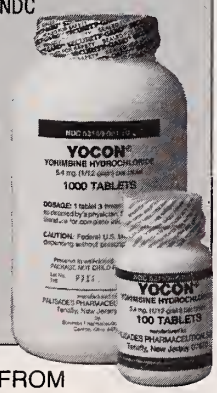

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16 — *Macon:* **Cancer Management Update 1990.** AMA Category 1 credits and AAFP prescribed credits. Contact Robert Fore, Ed.D., Medical Center of Central Georgia, 777 Hemlock St., Macon 31201. PH: 912/744-1634.

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22-23 — *Macon:* **Pediatric Emergencies.** AMA Category 1, AAFP prescribed, and ACEP Category 1 credits. Contact Mercer Univ. Sch. of Med., Office of CME, Macon 31208. PH: 912/744-1634.

23 — *Atlanta:* **Perspective in Parenteral/Enteral Nutrition — 12th Annual Metabolic Support Service Seminar.** Category 1 credit. Contact Jean Robinson, Pharm.D., Metabolic Support Service, Georgia Baptist Medical Center, 300 Boulevard, Box 235, Atlanta 30312. PH: 404/653-4499.

24 — *Augusta:* **Lyme Disease.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

26-30 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-30 — *Atlanta:* **Management Problems of Anesthesia & Life Support in the Cardiac Surgery Patient.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-31 — *Hilton Head Island, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

30-31 — *Atlanta:* **Expert Testimony.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

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"Of Libraries and Nurses and Books"

A nurse is a nurse is a nurse.
WITH APOLOGIES TO GERTRUDE STEIN

I am glad to be present and to attest to the friendly, cordial relationship which is and always has been first expressed and, most typically, between the physician and nurse at the bedside.... The nurse has been the greatest single aid to the physician in his services to mankind.... You are passing through a great crisis in your professional advancement.... The Medical Association of Georgia stands ready to support you in the future as it has in the past, to endorse such measures as lead to better and more nursing care to more of our people, and to assist you in establishing a higher ethical performance of your duties, and more satisfying personal rewards in their doing.
G. Y. MOORE, M.D., PRESIDENT OF MAG
ADDRESS TO GEORGIA STATE NURSES ASSOCIATION, 1930

To care for the bodily needs of the patient; to carry out the physician's orders: to keep a careful record of the happenings of the sickroom as regards the vital phenomena of the patient. Everything that the nurse needs to do and know may be grouped under one or another of these functions, and any teaching that contemplates anything beyond this would merely burden the nurse with useless theory or inspire her with the erroneous and fatal idea that she is endowed with the knowledge and skill of the medical attendant.
W. A. NEWMAN DORLAND, M.D.
EARLY 20TH CENTURY CHICAGO SURGEON

Come and take choice of all my library, And so beguile thy sorrow.
SHAKESPEARE: TITUS ANDRONICUS, IV, 1594

I no sooner come into the library, but I bolt the door to me, excluding lust, avarice, and all such vices, whose nurse is idleness, the mother of ignorance, and melancholy herself, and in the very lap of eternity, amongst so many divine souls, I take my seat, with so lofty a spirit and sweet content that I pity all our great ones and rich men that know not this happiness.
ROBERT BURTON:
THE ANATOMY OF MELANCHOLY, II, 1621

A hospital for the mind.
INSCRIPTION OF THE LIBRARY AT ALEXANDRIA, EGYPT

We must give credence... to the books we find, through which old things are recalled, and to the teaching of the sages of old, and trust in the old approved stories of holiness, of reigns, of victories, of love, of hate, and various other things.... And if old books were away, the key of memory would be lost.... And, as for me, though I know but little, I delight in reading books and hold them in reverence in my heart.
GEOFFREY CHAUCER

Here are some who seek health, and some who wish for death. Here comes the physician to heal and to teach, and the student to observe and to learn. Here comes charity to relieve, and religion to console and the foul blight of municipal politics to annoy, to hamper and to curse; and here among some of the worst men living and the most unfortunate, comes woman, white capped and cheerful to comfort and to bless.
J. CHALMERS DA COSTA, M.D.
19TH CENTURY PHILADELPHIA SURGEON

YOU HAVE TO MARRY ONE to know one. Or so they say. I did that. Married a nurse, that is. It all began in the library at the little Methodist College. The most unusual and diverse things happen in libraries. Some go there to rest, to sleep — for their quietness challenges death itself. Others frequent them for company. Romance is not an infrequent biproduct of hours spent there, for they attract like minds and dispositions. Annie Dillard, who wrote such things as *Pilgrim At Tinker Creek*, found the quietness and the isolation of the stacks a catalyst to creativity.

Some even go there for educational advancement. But I, I had gone simply for a quiet environment and a table upon which to study. Into that repository of the world's wisdom on a particular evening wandered the nurse of my future years. My life was never to be the same.

The stereotype was in my mind. White cap, white shoes, controlled disposition amid crises, calm to the point of distraction. And so she proved to be. Then of a sudden it happened. The children came. One after the other. She changed. The nurse became the nursemaid. Became the mother. Life changed and with the changes the requirements. A Resident needed support. Sympathy. Help. Overdue charts to be completed at midnight and rounds at 6 a.m. And her there. It was over and now a family to raise. To teach. To guide. To train, But then the time demands left her alone. A home to run. She became a manager. Family demands. Social demands. Why, indeed, her own life to lead. And she simply a nurse.

"What is a nurse as you might define that person today," I had said to Clair Martin and Mary Woody, he the Dean of the School of Nursing at Emory and she the Director of Nursing at Emory Hospital. We were having a "conversation" that day concerning nursing and the RCT issue. You will find it printed elsewhere in this *Journal* beginning on p. 83. It would have been an easy query 20 years earlier. Why, "a clean and healthy appearing young women clad in stiff white with cap atop her head. Standing quickly and bowing when the physician enters the ward. Offering him her chair. Jotting brief notes of bodily function upon the record between bed baths and bed pan emptying. She is your helper." That would have been the reply. "She" had of custom been the product of a Diploma School. Perhaps with little secondary education beyond high school, if even that.

"She looks me straight in the eye and tells me that she has planned carefully and worked diligently to arrive at this place in the health care arena where we both, nurse and physician, find ourselves. She wants no concessions not fairly gained. She wants no reimbursement for effort not expended but yet asks that this reimbursement be channeled through other than diverse byways."

Not so easy the answer now, however, to that question. The nurse now more likely was the product of a college or university connected program. She came with a degree. She was yet a helper but more than this an equal in the health care team. She talked of direct reimbursement for service rendered. She partitioned the legislative bodies on her behalf. She was no longer simply a nurse, but rather a nurse oncologist, an enterostomal therapy nurse, a nutritional nurse. She had specialized. She was organized.

I listened to the erudite and informed description of a nurse being given to me by these two people, themselves the directors of an institution committed to the task of training and educating the nurses of tomorrow. I thought back to that day in the Emory library. To the fragile young woman who wandered in that evening now so long ago. That someone else, the nurse of my todays and my tomorrows now stood, or sat, before me much as had the nurse of my yesterdays. Calm, efficient, compassionate. But somehow different. She looks me straight in the eye and tells me that she has planned carefully and worked diligently to arrive at this place in the health care arena where we both, nurse and physician, find ourselves. She wants no concessions not fairly gained. She wants no reimbursement for effort not expended but yet asks that this reimbursement be channeled through other than diverse byways. She wants no mandated dress code other than that designed in participation. Her white cap sits atop her head not as it once did, nor as often, but when present it carries but a different tilt. Meet then, ye physicians, your nurse of today. Educated, confident, individualist, self assured partner.

She was gone now. The nurse of my younger years. The mirage, the fantasy of yesterday had somehow floated gently and quietly out of my life. Her place had been taken by someone else. The devotion to duty, to menial tasks even, the compassion, these basic and soul-sustaining qualities yet survived. Shed, gone forever, was the blind adherence to protocol and with that, needless and constricting social bondage. She stood before me now, the nurse, asking for fairness and reason. For professional and social equality.

CRU

Nursing is an art; and if it is to be made
an art,
it requires as exclusive a devotion, as hard
a preparation, as any painter's or sculptor's
work;
for what is the having to do with dead
canvas or cold marble,
compare with having to do with the living;
it is one of the Fine Arts;
I had almost said,
the finest of the Fine Arts.

Florence Nightingale

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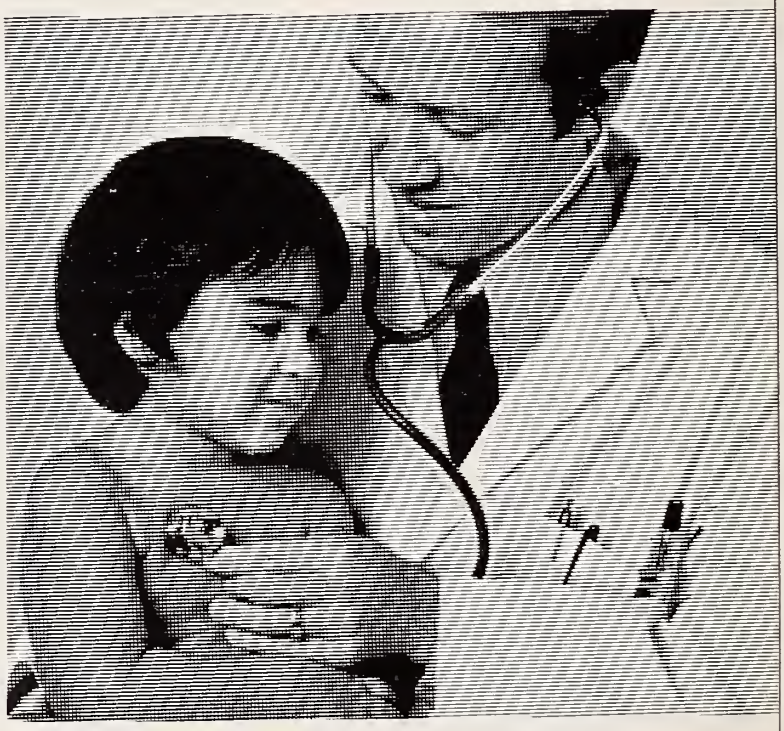

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The benefits package available to Army Family Practitioners is quite attractive. You'll receive 30 days paid vacation, opportunities to continue education and conduct research, a chance to travel, and reasonable work hours.

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Nursing Research

Betty Hamilton, R.N.

IT SEEMS LIKE an appropriate time to write an article about nursing research. The timing is right; health care resources are becoming more limited. The public is demanding quality care at lower cost. A question on the minds of most Nursing Administrators today is how to continue to provide quality care with less reimbursement and less allotted time to treat patients.

Nursing's response to this dilemma has been noteworthy. The profession has come up with a multitude of new patient care approaches attempting to find solutions to the issues at hand. Most new approaches focus on mechanisms for restructuring nurses' roles in delivering care or redesigning the work environment. These are being called "Innovative Nursing Care Delivery Models."

We now have **Differentiated Nursing Practice** models which define the nurses' clinical competencies based on education and/or demonstrated skill levels. Nursing is perceived as a wide range of functions from very simple tasks to the most complex level of decision making. Care assignments are based on the predetermined competency level of the individual nurse.

Case Management is another new method of providing nursing care. It is designed to facilitate the achievement of expected patient outcomes within a designated length of stay. Through a **managed care process,** common DRGs are targeted. **Critical Paths** are established which specify the key functions that must occur in a predictable and timely fashion in order to achieve the appropriate length of stay.

Nursing Group Practices take case management one step further. This model joins specific nurses together across multiple units into group practices. For example, these group practices manage the patient's care as they move from ICU to Neuro to Rehab, and sometimes to an outpatient setting. Using the **Critical Path** approach, timely intervention by nurses and physicians is accomplished and the desired and specific outcome stays within the predetermined time frame.

There have been **Quality Circles** and **Collaborative Practice Models.** We now have **Nurse Extenders** and in some states **Registered Care Technologists.** There seems to be no end to innovative approaches that are being developed. But I ask you, What is really new about all this? Nurses themselves have always risen to the occasion and come up with the innovative ways to deliver patient care, and I am convinced they will continue to do so.

"With changes in practice through a practical clinical research approach comes new directions, new challenges, and a new pride in nursing's contributions through a scientific inquiry approach to solving today's nursing problems in this complex environment."

Ms. Hamilton is a registered nurse who has come through bedside nursing, administrative nursing, and now finds herself in a fulltime hospital administration position as Assistant Administrator for Patient Services at Kennestone Hospital in Marietta.

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Perhaps one way to solve some of the many problems facing health care institutions today is to ask the nurses who are the major care givers for some answers:

1. What interventions and outcomes should be happening to this patient that will positively influence the patient's final outcome?
2. What is actually happening?
3. If it didn't happen, why and how can I make it happen?

It seems like these questions are part of the "spirit of inquiry" that is the basis for clinical research.

Taking nursing research from the classroom or nursing journals to the nurses' clinical setting can be exciting. Curiosity as to what's happening or not happening with patients is the factor that often leads to changing the way of doing things that have become long standing habits and rituals that are hard to change.

Change is never easy because it involves giving up many things that have become part of our practice and our "very being." However, with changes in practice through a practical clinical research approach comes new directions, new challenges, and a new pride in nursing's contributions through a scientific inquiry approach to solving today's nursing problems in this complex environment. ■

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Delivering Obstetrics From Liability Crisis

Murray A. Freedman, M.D.

What began in the 1970s as a national medical-liability crisis because of rapidly escalating malpractice insurance premiums and coverage availability has now begun to seriously affect the delivery of obstetrical care in the 1990s. A recent study by the Institute of Medicine of the National Academy of Sciences (published in the October 12, 1989, *New England Journal of Medicine*) concluded that, "The professional liability problem adversely affects delivery of obstetrical services, especially to disadvantaged women, those living in rural areas and those with high-risk pregnancies."[1]

'In 1987, there were 67 Georgia counties where no obstetricians were delivering babies; that figure now has increased to 95 counties.'

In 1987, it was estimated that approximately 22% of Georgia's obstetricians had discontinued obstetrical services. A report from the MAG Mutual Insurance Company found an additional 15% of their obstetricians and over 20% of the family practice physicians had stopped delivering babies in fiscal year 1987 and 1988.[2] National data (from the American College of OB/GYN) reveal that of those discontinuing obstetrics, 70% are under 55 years of age and almost 50% are under 45.[3] In 1987, there were 67 Georgia counties where no obstetricians were delivering babies; that figure now has increased to 95 counties.[4] Additionally, there are 70 counties that have no obstetrical facility whatsoever. Data from the Georgia Council on Maternal and Infant Health indicate that the number of deliveries in Georgia has increased approximately 3,000 deliveries per year since 1984.[5] This translates to a 25% increase in the number of deliveries in Georgia over the last 5 years, and this is coupled with the alarming attrition rate among physicians (and midwives) delivering babies.

Many obstetricians are refusing to take care of high-risk women because of this fear of litigation. This has even more of an impact on the low-income patient. The National Institute of Medicine study referred to above reported that "60% of Medicaid programs and almost 90% of maternity and infant health programs are having trouble ensuring the participation of sufficient numbers of providers of maternity care."[1]

'A total of 73% of practicing obstetricians in the United States have been sued; 40% have been sued three or more times. This degree of liability is simply intolerable.'

There has been a public misconception that the crisis in obstetrics is primarily an economic one because of high premiums. On the contrary, the obstetricians' anxiety and stress are the key factors responsible for doctors abandoning their obstetrical practice. The ACOG estimates that an average obstetrician will be sued eight times in a 35-year career.[6] A total

Dr. Freedman is Past President of the Georgia Obstetrical and Gynecologic Society. He is Associate Clinical Professor, Department of OB/GYN and Department of Physiology and Endocrinology, Medical College of Georgia, and in private practice. His addresss is 820 St. Sebastian, Ste. 6-C, Augusta, GA 30910.

of 73% of practicing obstetricians in the United States have been sued; 40% have been sued three or more times.[7] This degree of liability is simply intolerable. The United States has one of the best medical care systems in the world, yet we have three times as many lawsuits as any other country. There is truly a liability crisis — not a medical malpractice crisis.

"We have a true obligation to society to address this liability crisis. Significant tort law reform is necessary to stem the tide of OBs quitting practice."

Medical science does not know the cause of cerebral palsy. Nelson and Ellenberg have shown that only 10% of infants delivered with cerebral palsy are causally related to the birth process, and electronic fetal monitoring has not proven effective in preventing it.[8] The problem with the current tort law system is that the physician is held not only accountable but *responsible* for the vast majority of neurologically impaired infants.

The trend toward declining availability of obstetrical care in Georgia is serious. This is most pronounced in rural areas and in the indigent population. In this liability crisis, the true loser in the scenario is the patient. We have a true obligation to society to address this crisis. Significant tort law reform is necessary to stem the tide of obstetricians quitting practice. The anxiety in practicing obstetrics is simply too great; the joy of delivery has been replaced with fear of litigation.

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Falling Out of Love

Alfred A. Messer, M.D.

"The first task in successful marriage treatment is to help the couple recapture their lost idealization of each other."

FOURTH YEAR medical students spend most of their time as clinical clerks in specialties: medicine, surgery, pediatrics, obstetrics, etc. The student interviews a patient, does physical and laboratory examinations, and then presents his/her findings to a senior doctor who listens and teaches.

It was in this pursuit that I arrived at Columbia-Presbyterian Hospital one fall to begin my psychiatry clerkship. The patient assigned me that first day was an 18-year-old girl, Clare, with a problem I've now seen hundreds of times in practice. Clare began dating a boy at 15. They were with each other almost every day for 3 years. Now she wanted to take a recess to "explore other kinds of relationships."

Each time she hinted at this, Jimmy would go into a frenzy. ("I love you. I can't be without you.") Clare would back away. Once, when she said it out loud, the boy, who worked gainfully and had his own car, yelled, "I'll wrap my car around a tree if you leave me!" Clare states, "I don't want Jimmy to kill himself but I want us to be free to go out with others. How can I do this?"

It was a hot September day, and I had just ridden from downtown New York to 168th Street on a crowded, lunchtime subway train. "Have you tried garlic?" I asked authoritatively. Clare looked at me, bewildered. Her instructions: eat garlic abundantly before going out that evening. For good measure, she was to rub a garlic clove over her arms and neck; she was to be close physically; repeat this prescription four times, no matter what. My teacher was amused, and agreed we would wait and see.

Clare came in a week later and her smile told everything. After two dates, Jimmy announced they would stop seeing each other for awhile.

People in love over-idealize each other — physically, intellectually, artistically, etc. They envision the lover as making up for all past hurts. They overlook each other's shortcomings, unless an issue is so intense that confrontation cannot be avoided. Jimmy could not avoid the overpowering garlic.

The traditional advice to couples getting married was always to "work at the relationship; dress up for each other; call each other by endearing names; buy food or music or suggest movies that he/she "loves"; pay attention to the special needs of the spouse and fulfill these whenever possible. Each would then feel, "my partner is really devoted to me." Two people thus keep the idealization on track.

The train can go in the opposite direction, toward de-idealization if couples are unaware of needs or wishes. Bill and Nancy were both 18 when they married, just after high school. Both sets of parents opposed vigorously, urging college instead. But when Bill and Nancy threatened to elope, the parents relented. The young couple pledged themselves to find jobs that paid well, live in a small apartment for several years while they saved for a house, then start a family. "We'll show our parents that we an make it fine," they told each other triumphantly.

Dr. Messer is a specialist in family psychiatry. His address is 3332 Valley Rd., Atlanta, GA 30305.

And so it went for 2 years. Then Bill's company re-located, and he was out of work. "I'm tired and I'm taking a month off," he told his wife. She still got up each day at 6:00 a.m., cooked breakfast, and was gone by 7:30, about the time Bill was rolling over in bed. A few days running, Nancy came home at 4:30 p.m. to find Bill still in bed, reading or watching television. She hit the ceiling.

"That's not the deal we made," she exploded. "I can't stand lazy people. You're not even looking."

Bill's response, "Don't worry. I'll find a good job. I've got the rest of my life to work. I deserve this month off."

Nancy's rage festered, then turned to bitterness, then to silence. Before the month was out, she packed up and returned to her parent's home. She filed for divorce. She would not hear of counselling or trial reconciliation. Her husband had broken the contract they agree to; more importantly, he had shattered the ideal. The first task in successful marriage treatment is to help the couple recapture lost idealization.

Other examples of de-idealization: Who can forget the plaintive cry of the young boy upon learning that his Chicago baseball hero had been involved in throwing a game: "Say it ain't so, Joe." Or the 101st Congress trying a flanking maneuver to get a pay raise. One freshman member joked, "This is the first time a lawmaker gets a big jump in pay for not voting." The rage and disillusion among 85% of the public at the callousness of this act forced the legislators to cancel the salary hike.

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Registered Care Technicians: A Roundtable Discussion

THE AMERICAN Medical Association (AMA) recently proposed a solution to the nursing shortage by recommending that a new category of nursing personnel called Registered Care Technicians (RCTs) be established. In response to this proposal, and the reaction it has generated in the medical community, the Journal *convened a panel to discuss the issue and its ramifications. Dr. Charles Underwood, editor, served as moderator. Panel members were Clair E. Martin, R.N., Ph.D., Dean of Emory University School of Nursing; Harrison L. Rogers, M.D., past president of the AMA; Vi Naylor, R.N., Director of Professional Services at The Georgia Hospital Association; and Mary Woody, R.N., Emory University Hospital Director of Nursing.*

The RCT Plan was not introduced to be competitive with nursing; it was introduced as a way of bringing more people into nursing. (ROGERS)

Is there a need to set up a parallel system which could conceivably drain potential students from nursing education programs? (NAYLOR)

Dr. Underwood: I want to thank you all for being here. Among the many problems that physicians and hospitals face today is the need to provide adequate nursing care to hospitalized patients. I want this panel to address the issue of the nursing shortage, the RCT Plan proposed by the AMA to ameliorate this shortage, and concerns about that Plan which have been expressed by the American Hospital Association (AHA) as well as by a number of nursing organizations.

After everyone has made their opening remarks, you will have an opportunity to respond to each other's comments and to go into greater depth on any issues which you choose. Dr. Martin, we'll start with you. Is there a nursing shortage? If so, why? And how is Emory University's School of Nursing attempting to address the problem?

Dr. Martin: The nursing shortage is very real. However, from my perspective, the first thing that needs to be clarified is that this shortage is primarily a function of a dramatic increase rather than, as is often erroneously thought, a function of decreased supply. There are more practicing nurses today than at any other time. More than 67% of all registered nurses work in hospitals, and that is the group we're focusing on today. However, addressing the increased demand in hospitals will also give us some understanding of what is occurring in the community.

One key issue is that acuity of care has escalated dramatically, and this has been a major factor in increasing the RN/patient ratio from 52 to 97 per 100 patients. A second issue is that the aging of the population, combined with successful medical intervention, has increased the chronicity of the general population. The third factor is the new high-tech capabilities, such as transplants, which demand very labor-intensive nursing care.

Meeting to discuss the pros and cons of Registered Care Technicians are (L to R): Charles R. Underwood, M.D., editor, Journal of the MAG; *Clair E. Martin, R.N., Ph.D., Dean of Emory University School of Nursing; Mary Woody, R.N., Emory University Hospital Director of Nursing; Vi Naylor, R.N., Director of Professional Services, Georgia Hospital Association; and Harrison L. Rogers, Jr., M.D., Past President of the American Medical Association.*

I also want to talk about the issue of supply because supply and demand must both be addressed if we are to achieve a balance. For a number of reasons, nursing schools have seen a decline in enrollment, and that decline has received a great deal of visibility. At the same time we have an increased demand for registered nurses, we find a decreased interest in entering the nursing profession. Though the number of nurses is increasing each year, it is clear that demand will sharply exceed supply by the year 2000 if we don't recapture the interest of prospective nurses.

At the Emory School of Nursing, we have increased our enrollment of new students by 20% and 23% for the last 2 years, respectively. We have done this by looking at our curriculum for "goodness of fit" between the needs of prospective students and the needs of hospitals. We have also initiated a partnership between the school and the nursing service in order to make financial aid available. Sixty percent of the tuition for half of our entering class is paid by one of five hospitals in exchange for a commitment to seek employment there upon graduation. Developing these kinds of partnerships is one of the major recommendations in the final report from the Secretary's Commission on Nursing.

Nursing and teaching have traditionally been the major professional avenues open to women. However, new professional options now enable women to become physicians, lawyers, business leaders, or anything else they choose. At the same time, the number of high school graduates is decreasing. These two factors have resulted in a reduced number of nursing school candidates. We are therefore looking at non-traditional groups, including older individuals and non-whites, to recruit. By the year 2000, one-third of our population is going to be non-white. This means we need to find ways of attracting ethnic groups into nursing.

Given today's economic realities, most people will need to work a greater number of years than they had originally anticipated. This will result in three to five career changes for many people during their working life. We now have before the Board of Nursing a curriculum specifically tailored to people considering a career change, and we are focusing our recruiting efforts on the opportunities in nursing for this population. As a result of these efforts, we have increased the number of second-career people entering nursing. In fact, in this year's entering class, 35% of all students have a degree in some other area.

We are also trying to reduce the nursing shortage by closing the gap between nursing education and employment. Our total faculty has some obligation in the practice of nursing, and nurses have the op-

portunity to request teaching and research responsibilities. That is a tremendous inducement to prospective students because they can become part of an environment where the providers of care, teachers, and researchers all work together. To recruit nursing students, we must also aggressively profile exactly what we do, making the public aware that nurses enjoy the recognition appropriate to their responsibilities.

Cost-containment has resulted in RNs performing jobs that had previously been handled by other members of the health care team. So while nurses are prepared for and oriented towards patient care, the realities of the system result in their spending between 15% and 40% of their time in documentation and nonpatient care activities. If we are able to effect change in just one area, cutting the amount of documentation time in half will substantially reduce the 20% vacancy rate.

To recruit nursing students, we must also aggressively profile exactly what we do, making the public aware that nurses enjoy the recognition appropriate to their responsibilities. (MARTIN)

What I am suggesting is that we look very carefully at what nurses are doing to be sure that there is "goodness of fit" between what they were prepared to do and the job they are actually performing. I am also suggesting that we look at ways to adequately recognize and reward nurses for the responsibilities they assume. Our usual and customary ways of maintaining an adequate supply of nurses are no longer working. It is our job to turn this into an opportunity by trying some new ways of doing things.

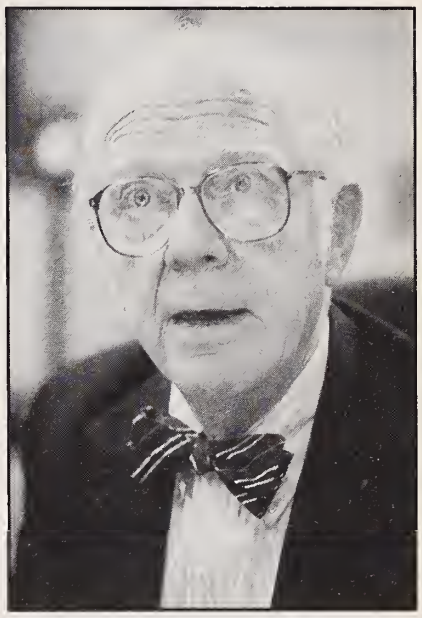
For the past 10 years, the AMA House of Delegates has been continually presented with resolutions by doctors who are deeply concerned about the nursing shortage and its effect on the timeliness of patient care. . . . The House has repeatedly told the AMA Board to take action to resolve this problem. (ROGERS)

Dr. Underwood: Thank you very much, Dr. Martin. Your comments have set the tone for this discussion.

Dr. Rogers, why did the AMA get involved in this issue when the nursing shortage seems to be a hospital issue? Why didn't you go to the American Hospital Association (AHA) and suggest sitting down to discuss the problem? Also, in your comments please address the AMA's proposed solution to the problem, the RCT Plan.

Dr. Rogers: The AMA is aware of the acute shortage of nurses. From 1983 to 1987, applications to schools of nursing decreased by 27%. The Department of Health and Human Services (HHS) estimates a current shortage of 200,000 nurses and projects the shortage will become even more severe. The AMA estimates a nationwide shortage of 500,000 nurses over the next 5 years, and there are shortages of LPNs as well as RNs. According to the Georgia Hospital Association survey, the LPN vacancy rate has increased from 5% to 15%, and the Nurse Assistant vacancy rate is also increasing dramatically.

As Dr. Martin documented, the need for nurses has increased as a result of a patient population which is older, more seriously ill, and receiving care which is more technical and more complex. I also share Dr. Martin's concern about nurses being taken out of practice to handle administrative and utilization review responsibilities. We are also losing hospital nurses to home health care services, doctors' offices, insurance companies, and outpatient facilities.



Dr. Harrison L. Rogers, Jr.

For the past 10 years, the AMA House of Delegates has been continually presented with resolutions by doctors who are deeply concerned about the nursing shortage and its effect on the timeliness of patient care. Though patients received magnificent care from nurses when one is available, the fact is that when the patient pushes the call button, it may be an hour or two before someone responds. The House of Delegates has repeatedly told the AMA Board to take action to resolve this problem. In response, the Board has been been working over the past several years with both the American Nurses Association (ANA) and the National League of Nurses (NLN). We have met on a regular basis, worked on joint projects, and supported legislation introduced by nursing organizations.

At the December, 1987, AMA meeting, a report on the nursing shortage, which in essence called for action, was presented by the Board and adopted. The report called for support of recruitment, education, retention, and all other efforts that would remedy the nursing shortage. The Report acknowledged that several approaches which had been undertaken, including working with nurses' associations, had been unsuccessful. The Board concluded in its report that we are facing an increasingly severe problem, one that is quickly becoming a real crisis.

As a result, the AMA Board of Trustees developed a proposal, the Registered Care Technologist Plan, which was presented to the House in June, 1988. The proposal was hotly debated, with approximately 50 doctors and nurses testifying before the Reference Committee. While nursing organizations representing RNs were uniformly opposed to the Plan, the LPN organization supported it. Though delegates representing doctors nationwide were divided, on balance they supported the Plan due to the seriousness of the nursing shortage.

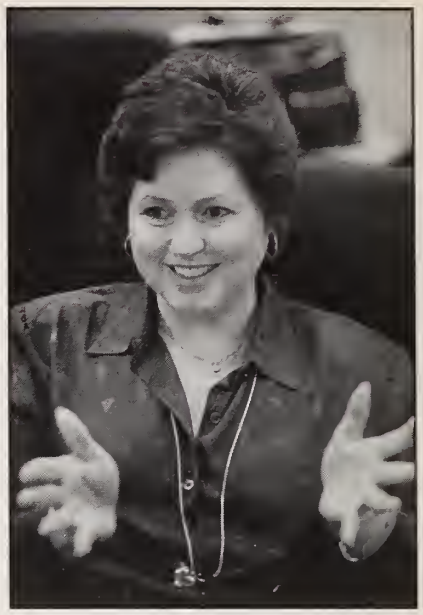
The Plan for RCTs described both the concept and the search for a pilot test site where the validity of that concept could be assessed. The RCT was defined as a high school graduate who, while working in a hospital, would receive training by the doctors and nurses. That training would be divided into basic and more advanced courses. Their responsibilities would encompass a very low technologic level which would exclude the performance of complicated procedures. The Plan would also provide an opportunity to bring people into the medical education system without financing their education. Bringing students into the hospital, training them for a brief period of time, and paying them while they were working and learning, was seen as a reasonable approach.

I want to emphasize that RCTs were viewed as additional health care providers, not as replacement for nurses. The RCT would not be a nurse, would not compete with nurses, would not substitute for a nurse, and would not be an independent worker on the floor. RCTs were envisioned as bedside caregivers under the direction of, and an additional arm for, the charge nurse on the floor. The RCT Plan was also seen as a potential recruiting tool for the nursing profession, as it would enable RCTs to see the future in health care and perhaps decide to enter nursing.

We need to evaluate the appropriateness of where nurses are being utilized and in what numbers they are needed in areas such as utilization and quality management. (NAYLOR)

Regarding the current status of the RCT Plan, the AMA Board has furnished the House with a report detailing their accomplishments since the previous meeting. The Board announced that they were exploring several funding sources for the project and that they were planning to look at the availability of existing training programs to see if one might be used as the pilot site. To reiterate, the goal of this pilot project is to provide a basis for evaluating the quality and cost effectiveness of RCT applicants for this level of responsibility.

Dr. Underwood: Thank you, Dr. Rogers. Your comments give us some insight into the thinking of the AMA and also raise some questions for later discussion. Ms. Naylor, from the perspective of the hospital, is there a problem in nursing? Why has the AHA opposed the RCT Plan as a viable solution? Is the Georgia Hospital Association (GHA) taking any action?



Ms. Vi Naylor

Ms. Naylor: Dr. Martin did an excellent job in outlining the problem as a demand driven imbalance between supply and demand — that we have more nurses today than at any time in history. With respect to the AHA, I am not sure that they have taken a stand against the RCT Plan. The Counsel on Nursing Professional Services and Education (CNPSE) stance with the GHA has mirrored the AHA position. CNPSE's position has been to look at the RCT Plan as one alternative for dealing with the nursing shortage, and also to look at alternate proposals recommended at the national level by the National League for Nursing (NLN), the American Nurses Association (ANA), the AHA, and our own American Organization of Nurse Executives (AONE), which should be also considered.

There are some very viable recommendations in those reports for dealing with the nursing shortage on both a short- and long-term basis. AHA and AONE have recently proposed a plan to help hospitals change the work environment by more effective use of the nurses' time. I concur with Dr. Martin that nurses need to be giving nursing care rather than being diverted to other areas of responsibility, but how one defines nursing care is the critical issue.

In my role with GHA and as a former Health Care Management Consultant, I recognize the need for nurses in areas other than for the provision of patient care, though perhaps not at existing levels. We need to evaluate the appropriateness of where nurses are being utilized and in what numbers they are needed in areas such as utilization and quality management. The perception has grown to an expectation that a licensed person must carry out every single order for the patient. Through the years, hospitals have been moving in that direction with the implementation of primary nursing with an RN staff. But when we don't have the numbers to operate in that manner, we have to look at alternatives. AONE will be helping hospitals identify those responsibilities which can be carried out with the help of assistant personnel.

The RCT Plan was also seen as a potential recruiting tool for the nursing profession, as it would enable RCTs to see the future in health care and perhaps decide to enter nursing. (ROGERS)

I have heard nursing administrators say that nurses want to handle all patient care. On the other hand, I have talked with nurses who do not want to perform some of the more menial tasks associated with nursing. Although in some cases it is appropriate for a nurse to bathe a patient or assist a patient with toileting, I don't think it is appropriate on a consistent basis. Nurses need to plan the care, supervise and manage the implementation of care, carrying out a portion of the care when appropriate, and evaluate the care. Nurses should be given ancillary support so that they have time to manage the patient's care from admission to discharge in order to assist the physician in delivering quality care.

During the last nursing shortage, I was in a hospital that implemented a concept called "modular nursing." A nurse and an unlicensed caregiver worked together to take care of more patients. The nurse determined which responsibilities he or she would need to handle for their group of patients and those which could be handled by the unlicensed caregiver. The RCT Plan, as Dr. Rogers has described it, sounds like the nursing technician that has been in place for years. If that is the case, is there a need to set up a parallel system which could conceivably drain potential students from nursing education programs? What about the additional costs of establishing another educational program.

I see the AMA goal of helping nurses provide care as being consistent with the AHA, GHA, and nursing education goal. We are all seeking the same outcome. The GHA has convened a number of multidisciplinary groups to look at the imbalance between supply and demand. We have established regional recruitment networks which have contacted the high schools, and we have tried to modify the perceptions of high school counselors who do not see nursing as a viable career choice. Increased enrollments this year indicate that such activities are working.

We are also focusing recruitment efforts on non-traditional students. We have asked the Georgia Association of Adult Educators and Continuing Education Directors in universities and community colleges to allow us to conduct short programs on entering the nursing profession. We are currently seeking external funding to finance a media campaign to improve the image of nursing.

In terms of retention, we have just completed a job satisfaction survey designed to identify factors in the work setting which are important to nurses. Once that information is available, we will use it to help formulate the GHA Program for helping hospitals increase nurses' satisfaction. The first look at the data shows that salary, autonomy, and a professional work environment, respectively, are the three top issues. I concur with the AMA that these issues cannot be addressed by education or nursing administrators working in isolation. There has to be a close working relationship among doctors, hospitals administrators, and nursing administrators.

Sixty percent of the tuition for half of our entering class (at Emory School of Nursing) is paid by one of five hospitals in exchange for a commitment to seek employment there upon graduation. (MARTIN)

Studies are currently being conducted by the AONE at hospitals using assisting personnel where the satisfaction and retention rates among nurses are high. We hope to be able to replicate what has occurred at these institutions in other hospitals. Toward that end, the GHA is currently pulling together a committee which will be looking at available national reports as well as at the RCT Plan. We have invited the MAG to meet with us to explore all alternatives, including the RCT Plan, for dealing with the nursing shortage. I believe that when we do sit down together, we will have identified some specific ways we can work together at the institutional level to effect needed changes.

Dr. Underwood: Thank you Ms. Naylor. Ms. Woody, as Director of Nursing at Emory University Hospital, please respond to these two issues: In the January, 1974, *New England Journal of Medicine*, there was an article entitled, "The Burlington Random Mass Trial of the

Nurse Practitioner." The results of that article stated that patients who received conventional care from family physicians were compared with those who received care primarily from nurse practitioners. The

Ms. Mary Woody

groups had similar mortality rates, and no differences were found in physical, social, or emotional functioning. The quality of care rendered to the two groups appeared comparable as assessed by a qualitative indicator condition approach.

So my first question is, remembering Dr. Roger's concerns about someone being at the patient's bedside, what is a nurse? And secondly, can anybody speak for organized nursing? We've heard about the AONE, the ANA, and a number of other groups. Who speaks for nursing?

Ms. Woody: In answer to your first question, the ANA includes some of the most amazing people I have been privileged to know, and quite frankly I feel honored to be part of this group. From a historical perspective, we can go back to biblical times when the nurses were of a religious order. Later, we referred to people who took care of young children as nurses. Though people have a wide range of images of what a nurse is, I think these references indicate how society in general has viewed nursing.

But when we define a nurse in today's terms, we are talking about a person who has graduated from an accredited school of nursing, who is licensed to practice by a state, and who possesses certain competencies and skills that will enable him or her to make judgments about patient care.

There are several paths that nurses can take including nurse practitioner and nurse mid-wife. The findings in studies that have compared the services of a nurse mid-wife to those of an obstetrician would be similar to the findings of the Burlington study. These nurses were found to be effective in delivering quality medical care. But we must acknowledge the need for nurse practitioners and mid-wives for the backup and support of physicians.

Concern has been expressed about the drain of nurses from direct care, but I believe it has been shown that nurses also need to be involved in health-related activities other than direct care. With respect of the current nursing shortage, nurses need to be recognized and supported at all times not just during a shortage. It should not take a crisis to bring about an interest in nurses and nursing.

One reason nurses are successful is because of our ability to manage a situation. We are available to fill in. If the pharmacist is out, we can get the medicine. If the administrator is unavailable, we can handle the problem. We known when it is, and is not, necessary to call the doctor. However, nurses don't always have the authority to do what needs to be done or the invitation to be appropriately involved in planning and policy making.

So, to answer your first question, Dr. Underwood, nurses are people who put out a lot of fires. Nurses are the ones who see the problems developing with a patient and recognize that intervention is needed. And nurses can frequently initiate this intervention on their own or in partnership with a physician or other health care provider. Also nurses are educators as well as practitioners.

The role of nurses as identified in the Burlington study has already been discussed. A study involving hospital intensive care units in Pennsylvania also addressed the role of nurses and showed patient survival in intensive care units to

When we define a nurse in today's terms, we are talking about a person who has gone through an accredited school of nursing, who is licensed to practice in his or her state, and who possesses certain competencies and skills that will enable him or her to make judgments about patient care. (WOODY)

be higher when nurses and physicians planned together. Joint planning also resulted in the patient's shortened length of stay in intensive care. So in summary, I see nurses as people who are critical to our health care system, our society, and our civilization.

Dr. Underwood: Please speak briefly to the issue of nursing organizations. On the national level, who speaks for nurses?

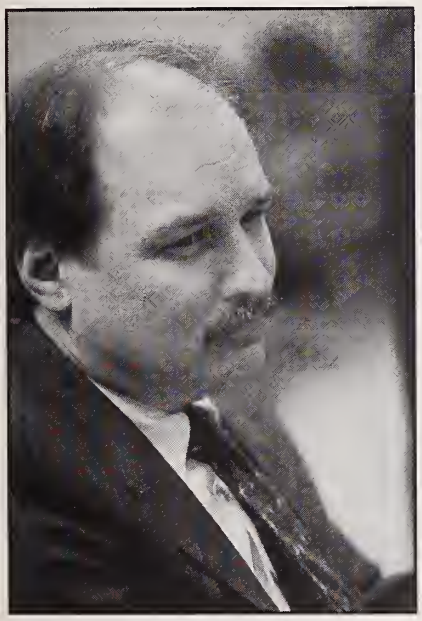
Ms. Woody: Because there are almost two million nurses, people frequently have the erroneous perception that we are unorganized, without a unified voice. Both ANA and AONE represent and speak for nurses; the NLN represents nursing education and accreditation; the American Association of Colleges of Nursing has the Deans Group that speaks from their perspective.

Specialization in nursing has resulted in organizations, such as the American Association of Critical Care Nursing, which also speak out on issues. And of course there are nurses who, as individuals, speak for themselves. In Georgia, the LPN Association has been very strong in the area of legislation. However, the LPN Association does not speak for professional nurses and the Georgia Nurses Association (GNA).

So, while I don't think there is one loud voice representing nurses,

there are a number of consensual voices speaking on the same issues. Regarding the RCT Plan, with the exception of the LPN Association, every nursing organization which I am aware of has opposed it.

Dr. Underwood: Thank you, Ms. Woody. Even though time did not permit us to get into every area, this has been an excellent review of the issue. I will now ask each of you to address any particular question or concern that arose during the initial discussion. Dr. Martin, please begin.



Dr. Clair Martin

Dr. Martin: The biggest question we have in health care today is not what *can* we do, but what *ought* we do? There is no question that we can demonstrate the effectiveness of the RCT investment. The question is whether we should. For the following reasons, I feel we cannot afford a demonstration RCT Program.

First, quality of care has to be the primary concern of all of us. The major theme that I hear from patients today, either directly or through the literature, is that health care has become dehumanizing, impersonal, and fragmented. The high level of acuity of care requires that knowledgeable, capable people be directly involved in that care, with the plan of care orchestrated by an advocate to insure that no patient falls through the cracks.

The doctor/nurse relationship has always been at the foundation of the health care system, and that relationship must change to reflect the social realities of a more egalitarian system. (MARTIN)

The second issue is cost containment. We cannot afford another group of health care providers. Though conventional wisdom says that a lesser educated person will be less expensive, hospital research is very clear that the lesser prepared person is not the most cost effective. A person with a higher level of training is able to assure that there is an individualized plan of care for the patient. Such an individual is also able to provide the physician with accurate assessment data which can be used to modify both the medical and nursing care plans. The RCT Plan, which puts less qualified people on the floor, is cost containment we simply cannot afford.

With respect to good will between doctors and nurses, for the most part men and women, respectively, what we are seeing in medicine is simply a reflection of what has been happening in society. Relationships between men and women have been troubled, and in the health care field we have a very intense environment in which this social phenomenon is being perpetuated. We need to be sure that the actions we take do not exacerbate existing problems between doctors and nurses.

The doctor/nurse relationship has always been at the foundation of the health care system, and that relationship must change to reflect the social realities of a more egalitarian system. Rightly or wrongly, implementing an RCT demonstration project will be perceived as indicative of a lack of appreciation of nurses by doctors. And, as Ms. Naylor pointed out, we need to do more than address the immediate nursing shortage; we need to interrupt the recurrent cycle of shortages. Five years ago there were national headlines about nurses being laid off. Now the Department of Labor is telling us there is going to be a 44% increase in new RN positions by the year 2000.

If we are going to resolve this problem, we need to talk straightforwardly with each other. The day of unilateral action is past; we have to find ways of risking collaboration. Perhaps a good place to start in Georgia would be by putting together a representative group to assess the recommendations of the Secretary's Commission on Nursing and develop a plan that would resolve the problem not just for now, but for the long term. I am convinced that if doctors, nurses, and hospital administrators are willing to work together, we will be able to produce an adequate supply of nurses for Georgia.

Dr. Underwood: Thank you. I'd like to hear from you next, Dr. Rogers.

Dr. Rogers: The RCT Plan was proposed in response to the perceived desperate situation that physicians nationwide found their patients to be confronting. High quality patient care is the primary goal of physicians. However, someone has to be there for any kind of care to be given, and there have been many situations in which someone has not been there. When I would make rounds in the morning, patients told of having pushed the call button for an hour and a half without response. When I spoke to the head nurse about the problem, she advised me that there had been only one nurse for the entire floor during the night. We both recognized that I was bringing her a problem she had no way of solving.

As Dr. Martin pointed out, the doctor/nurse relationship is an important issue. In the past, many physicians have regrettably ne-

glected to do their part to establish a good working relationship with nurses. But the RCT Plan was not introduced to be competitive with nursing; it was introduced as a way of bringing more people into nursing. One of the goals of the Plan was to call this person something different, a technician, and hopefully to recruit more men into the program. Men coming out of the service might not want to be called nurses because they perceive nurses as female. There is such a desperate need, and we think this plan is a way to bring in more health care providers.

Dr. Underwood: Thank you. Please make your closing comments, Ms. Naylor.

Ms. Naylor: In response to Dr. Roger's concern that someone be available to the patient, I have also heard several complaints about the lack of adequate care. When I asked for specific examples, I was told that nobody fluffed the pillows, or turned the patient, or just came in to check. Though we all know that those things are a very small part of nursing, they are the visible signs that families and the community see. But we must acknowledge that if someone had been there to provide those comfort measures, the whole family, not just the patient, would have been better cared for.

In terms of a collaborative approach, several years ago I was Director of a Duke Endowment Project designed to improve patient care by enabling doctors, nurses, and hospital administrators to communicate more closely. This resulted in decisions consistently being made which were in the best interest of the patient. In one instance, on an oncology unit, nurses were unable to implement their plan of care for 24 to 48 hours after a patient's admission because they did not have the history. Once this was discussed, physicians responded by making patient records available on a timely basis. This entire effort focused on doctors and nurses working together more effectively to improve patient outcome, and that is what we need to be doing now.

Dr. Underwood: Ms. Woody, your closing comments, please.

The RCT was defined as a high school graduate who, while working in a hospital, would receive training by doctors and nurses. . . . Their responsibilities would encompass a very low technologic level which would exclude the performance of complicated procedures. (ROGERS)

Ms. Woody: We need to build up, not tear down, the nursing profession. Nurses need more recognition and appreciation in order to make the field more attractive to potential nursing school applicants. Recruitment of students into schools of nursing is a major area that needs to be addressed. We also need to look at the number of junior college and baccalaureate programs in the state and determine what the supply and mix should be in order to get the best use of our dollar in planning for the future.

I would welcome the opportunity to sit down with the medical leadership, hospital administrators, and nursing directors to talk about our mission, goals, problems, and potential solutions. Nursing needs more help and, to reiterate, not just in times of crisis. I think doctors are gaining a greater understanding of what nurses actually do and some of the demands made on nurses.

Physicians and nurses all agree that we need to do something about our problem. But the RCT Plan does not address the current nursing culture or population. In fact, it is viewed as adversarial to nursing. It was my understanding when the Plan was first circulated that RCTs were to be trained under the supervision of physicians and licensed by the Medical Board. If RCTs are going to be trained and licensed by physicians, logic tells me that they are also going to be supervised by physicians. I don't see RCTs as additional resources for nursing. The Plan simply has too many conflicts for me to support it.

Dr. Rogers: I want to respond to the issue of training and licensure. In the original report, the model Ms. Woody just described was suggested as the mechanism by which RCTs might be certified. However, the second report modified that stance, acknowledging that we would need to assess the most appropriate way to handle training and certification.

Dr. Underwood: I think everyone has looked at the issues very honestly, and I want to thank all of you for participating. Perhaps the most striking aspect of this discussion was a point first made by Dr. Martin that the time is past for unilateral action in any area of medicine or nursing. Dr. Martin's recommendation that a representative group be established certainly needs to be given serious consideration by the MAG.

The Editors' Corner of the February, 1989, *Journal* ends with a quote by John Donne which might guide us in our efforts to resolve our current dilemma: "No man is an island, entire of itself; . . ." ■

Nursing Associations — A Precis

Clair E. Martin, Ph.D., R.N.

NURSES, through informed caring, are a positive force in the quality of contemporary health care. Currently, there are 2.1 million RNs in the United States. Eighty percent of these nurses are employed in nursing positions. Through a variety of organizations and associations, nurses collectively advocate quality, accessible health care, standards of practice, education and research, networking, and the rewards and status appropriate to their responsibility.

The twenty-fourth edition of the *Encyclopedia of Associations — 1990* lists over 200 nursing organizations. This number and diversity is a tribute to the interests and needs of a pluralistic membership, but is also an indication of an elusive unified focus. The purpose of this article is to briefly describe a few of the major associations that play a significant role in advancing the goals and interests of contemporary nursing.

This article briefly describes a few of the major associations that play a significant role in advancing the goals and interests of contemporary nursing.

National Organizations

American Nurses Association (ANA)

The professional nursing organization, ANA, was established in 1896 to provide one voice for nurses. The primary goal of the ANA is to provide the public with quality nursing care and to protect the welfare of individual nurses. ANA sets standards for nursing practice, including a code of ethical conduct. In 1973, ANA initiated certification examinations in 13 specialty areas. The ANA's professional journal is the *American Journal of Nursing.*

In 1954, the ANA House of Delegates established the American Nurses Foundation to support the research and projects of nurses. This focus has been broadened to include the analysis of health policy issues, nursing career development, and facilitation of the Association's education and research activities. In 1966, the House of Delegates created the American Academy of Nursing to recognize professional achievement and excellence. The Academy was established in 1973 and has become a positive force in advancing the science that informs the practice of nursing. *Nursing Outlook* is the official publication of the American Academy of Nursing.

ANA membership is through state and territorial nursing associations which are comprised of local districts. The Georgia Nursing Association is a constituent of the ANA.

National League for Nursing (NLN)

The National League for Nursing was established in 1952 by a merger of the National League of Nursing Education with five related associations. The NLN is open to both individual (including nonnurses) and agency membership. The NLN's mission is to provide a link between organized nursing and the health care needs of the community. To this end, the NLN provides accreditation services for both educational and service nursing agencies, offers consultation and continuing education, promotes

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quality education, provides testing and evaluation services, develops mechanisms which anticipate changes in consumer needs and the health care delivery system and facilitates nursing's response to them, and promotes nursing research. *Nursing and Health Care* is the official journal of the NLN.

National Student Nurses Association (NSNA)

The National Student Nurses Association was established in 1953. Students who are enrolled in approved schools of nursing are eligible for membership in their local state and national Student Nurses Association. Recruitment of nursing students and the development of their leadership and contribution as future health professionals is the goal of the NSNA. The NSNA publishes an annual career planning guide, *Dean's Notes,* and *Imprint.*

Sigma Theta Tau International

Founded in 1922, Sigma Theta Tau International is the honor society for nursing. It has 264 chapters in NLN-accredited college and university nursing programs. Sigma Theta Tau is dedicated to enhancing leadership, creativity, and scholarship and promoting research within the discipline. Its major publication is *Image.*

National Council of State Boards of Nursing (NCSBN)

The NCSBN was founded in 1978. It facilitates the administration of the National Council Licensure Examinations for Registered Nurses and Practical Nurses by its member state boards of nursing. It also aids the state boards in collecting and analyzing licensure and disciplinary information. In addition, it provides consultative services and research related to model nursing legislation and regulations. Its major publication is the *National Council of State Boards of Nursing Newsletter.*

Speciality Associations

American Association of Colleges of Nursing (AACN)

Founded in 1969, the AACN aims to improve professional nursing through enhancing the quality of baccalaureate and graduate programs, facilitating research, and developing academic leadership. The promotion of legislation influencing health care delivery and health personnel education has been a significant commitment of the AACN. Baccalaureate and graduate nursing education programs are eligible for agency membership and are represented by their deans or directors. The *Journal of Professional Nursing* is its major publication.*

American Organization of Nurse Executives (AONE)

Founded in 1967, the AONE membership of nursing service administrators supports the development of effective nursing service administration through its programs. The AONE is affiliated with the American Hospital Association and publishes a monthly newsletter, *The Nurse Executive.*

Association of Operating Room Nurses (AORN)

The AORN was established in 1949. Its members are registered nurses who are engaged in the supervision, teaching, or staffing of operating rooms. The primary aim of the AORN is to improve the standard of operating room nursing care through the development of the knowledge, skills, and leadership of its membership. The *AORN Monthly Journal* is its publication.

National Black Nurses Association (NBNA)

The NBNA was founded in 1971 for all levels of nurses, including student nurses, to serve as a professional support group and to advocate quality health care for the black community. It also is active in recruiting blacks who wish to pursue a career in nursing and facilitating their entry into the profession. The *Journal of Black Nurses Association* and the *NBNA Quarterly Newsletter* are published by the NBNA.

American Association of Critical Care Nurses (AACN)

Established in 1969, the AACN supports the nurses who specialize in critical care through its education and certification programs. The AACN develops standards for both the education and practice of critical care nursing. Its primary publication is a bimonthly journal, *Focus on Critical Care.*

American Association of Nurse Anesthetists (AANA)

Founded in 1931, the AANA aims to develop the art and science, research, and educational standards and programs that support nurse anesthetists. Certified nurses anesthetists are eligible for membership.

Nurses Association of American College of Obstetricians and Gynecologists (NAACOG)

Formed in 1969, NAACOG aims to promote standards of practice, education, and research in OB/GYN nursing. Its members are registered nurses and associate members are allied health workers with an interest in obstetric, gynecologic, and neonatal nursing (OGN). NAACOG offers certification in OGN nursing. The *Journal of Obstetric, Gynecologic, and Neonatal Nursing* is its major publication.

Oncology Nursing Society (ONS)

Founding in 1975 to promote professional standards of oncology nursing practice, ONS provides educational programs, supports research, and provides an information exchange network for its members. The *Oncology Nursing Forum* is its primary publication.

Additional information concerning the associations described may be found in the *Encyclopedia of Associations* or by consulting with a nurse. Each of these associations have a rich history and maintain a program of activity that is beyond the scope of this article to describe. In addition, there are many more associations, ranging from the International Flying Nurses Association to the American Society of Post Anesthesia Nurses to the American Assembly for Men in Nursing. Collectively, these associations strive to enhance the welfare of both the public we serve and the profession we represent. ■

*Dr. Ada Fort, Emory University School of Nursing Dan Emeritus, was a founding member and first secretary of the AACN.

"The Best of Times, The Worst of Times"

Evelyn C. Waugh

"It was the best of times, it was the worst of time," wrote Charles Dickens in his opening paragraph of *A Tale of Two Cities*. And this same assessment could well be used to describe the health care situation in which nurses — indeed all professionals — find themselves practicing today.

Never have the opportunities been so exciting, so stimulating, so challenging, and never have the demands been so frustrating, so constant, so seemingly impossible. As a professor recently remarked to his class, "This is a most exciting time in healthcare. I'm glad I'm not a part of it."

Nursing administrators are part of it — indeed, a part that sometimes experiences the excitement, but more frequently deals with the challenges and frustrations. Through the Georgia Organization of Nurse Executives and the national organization, opportunities are available to interact with nurses in similar roles, to participate in educational activities, and to keep up to date with issues, questions, and answers on a statewide and national basis.

In the past, women primarily had two choices in selecting a career: teaching or nursing.

Through the Georgia Organization of Nurse Executives and the national organization, opportunities are available to interact with nurses in similar roles, to participate in educational activities, and to keep up-to-date with issues, questions, and answers on a statewide and national basis.

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Traditionally, women who chose nursing did so from altruistic motives: they wanted to care for people who were sick, and to relieve pain and suffering. Their greatest source of satisfaction came from direct contact with patients, and from ministering to their needs. The nurse's job description matched very closely the nurse's expectations. Not only did it meet her expectations, it was also exactly what patients expected — kind, expert care during a crisis, and gentle, supportive encouragement during the days of convalescence.

Nurses experienced a great deal of job satisfaction in performing their role and were held in high regard by society. It was a good time in many ways, though certainly lacking in the resources we take for granted today.

The philosophy that health care is a basic right, along with the medical/scientific/technologic advances over the past 25 years, necessarily produced major change. The challenge for nursing administrators in those years was to plan and educate for those changes.

Nurses, always interested in learning and implementing new methods of treatment, responded eagerly. Their job descriptions were

modified to accommodate the changes, but they found it exciting and rewarding. Hospitals grew in size and number. There were new critical care units, nursing salaries increased, diagnostic and monitoring equipment was available, and there was easy access to health care. Despite a shortage of nurses, the increase in general inflation and health care costs, certainly it seemed these were indeed the best of times.

Within the past 7-8 years, however, changes have occurred that are causing many to wonder if this may not also become the worst of times.

Might we become unable to use the knowledge and technology we have available due to inadequate financial resources? Health care costs are the culprit, we are being told from every direction, and they must be reduced. Through reimbursement techniques, third party payors are making certain that hospitals respond.

Since nursing is generally the largest division in most hospitals, cost reductions affect nursing departments early and, frequently, painfully. It is a fact that patients in hospitals today are acutely ill. Many patients on general units today would have been in intensive care five years ago, and those who were in general units five years ago are at home today, cared for by family, home health nursing staff, or whoever may be available.

Logic would direct that sicker patients and increased technology would call for increased numbers of nursing staff with higher degrees of skill. Instead, most nursing administrators find themselves using fewer staff, and substituting persons with less preparation and experience at the same time.

While the nursing shortage is partially responsible for this reversal in logic, an equal culprit is the reduced budget within which most nursing administrators must work. As physicians observing staffing within hospitals, you may be certain that every nursing administrator you know is struggling to determine the best mix of staffing for her particular institution and budget, and once determined, the best recruitment and retention strategies to keep positions filled — again within the budget.

As a different mix of staff is used to provide patient care, the emphasis on education and role change must increase. Not only are many hospitals again teaching nursing assistant courses and other on-the-job training skills, but they are also teaching supervisory courses.

Economics may dictate that the RN no longer provide "total patient care," but it becomes the responsibility of nursing administration to help nurses achieve job satisfaction through other direct patient care activities.

Many RNs who have been accustomed to providing direct patient care since graduation from nursing school are now being asked to provide supervision of other staff members. They are experiencing the need for management skills such as making assignments, planning care, delegating and dealing with conflict.

Again, job descriptions have changed. But these changes adding new responsibilities and deleting older, more familiar activities, are not necessarily welcome. Many nurses tend to resent patient care management activities that they perceive to remove them further from direct patient care. Also, the patient may complain that he or she "hasn't seen a nurse" during his or her hospital stay.

Keeping in mind the economics of the situation, the challenge for nursing administration is to restructure the nursing care delivery system in such a way that quality patient care is provided, while at the same time ensuring that staff nurses retain the satisfaction associated with direct patient care.

Economics may dictate that the RN no longer provide "total patient care," but it becomes the responsibility of nursing administration to help nurses achieve job satisfaction through other direct patient care activities — assessing, planning nursing care with and for the patient, evaluating the care given and the outcomes, planning for discharge and teaching — all activities that are now mandated by professional and licensing bodies as specific RN responsibilities.

Historically, times of chaos and disequilibrium within the environment have provided the opportunity and the breeding ground for constructive change. While most would not accept chaotic as the accurate term to describe the health care system today, many would agree with disequilibrium. From a situation such as exists today come the opportunity for change — for medicine, for nursing, and for health care administration.

Because medicine and nursing share many of the same ideals and values, they also share similar concerns. What will be the quality of care 10 years, 20 years from now? Will it be accessible to all those needing it? (With apologies to Pogo, many of them will be us!) Will the practice of medicine and nursing be significantly changed? What will be the relationships between the medical and nursing professions? Will our values and objectives continue to be complementary?

As I talk with nurses — those practicing clinical nursing and those in other roles, those who are giving thought to the future, as well as trying to survive in the present — some common values emerge:

- Nurses want to continue to serve the sick and dying, those who are in pain and suffering and those who need assistance to prevent illness. They do not want to do it only for those who can afford to pay.
- Nurses want a future in which medicine and nursing practice in a collaborative style, each respecting, sharing, and contributing that which belongs uniquely to each profession, brought together for the good of those they serve.

Not only are many hospitals again teaching nursing assistant courses and other on-the-job training skills, but they are also teaching supervisory courses.

- Nurses want their practice to be based on well-established principles, not simply tradition, which means that research into nursing practice must be conducted and routine activities justified.
- On the practical side, nurses want access to support services, to time-saving information, and to new technology, but even more they want enough time to provide a quality of patient care for which they need not apologize.

Will these values survive the changes that will surely take place in the coming years? Are they enduring enough to be appropriate in the new tomorrow of health care? Will that tomorrow be the best of times, or the worst of times???

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The Georgia Nurses Association: An Advocate for Nurses and Patients

Lynda McSwain

THE GEORGIA NURSES Association (GNA) is the professional organization for registered nurses in this state. GNA was organized in 1907 in Savannah by a group of caring nurses with exceptional foresight. The purpose of the organization, then and now, is to provide services that protect the welfare and increase the knowledge of individual nurses, programs that enhance and upgrade the profession of nursing, and activities for the protection and advocacy of patients, the consumers of nursing care.

To meet the established purpose, GNA has developed Cabinets on Nursing Practice, Nursing Administration — Nursing Education, Research, Economic and General Welfare, Continuing Education, and Governmental Affairs. It is through the Cabinet on **Continuing Education** that the nursing organization develops, approves, and provides credit for educational workshops, seminars, and meetings which keep nurses up to date with the latest improvements and technology in health care.

The Cabinet on Nursing Practice has developed Councils for various interest groups where nurses meet and discuss the problems, issues, and needs in their specific practice area, i.e., community health, maternal and infant care, gerontology, medical-surgical care, etc. By sharing experiences in practice areas, the nurses learn new techniques, debate practice issues, and hear about what works and what doesn't work in resolving problems of their particular specialty.

Like most service professions, nursing has long had the debate between educators and service providers as to what the practitioner of the profession should know and do. GNA has attempted to address this issue by developing the **Cabinet on Nursing Administration-Nursing Education** in which educators and

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The purpose of the organization, then and now, is to provide services that protect the welfare and increase the knowledge of individual nurses, programs that enhance and upgrade the profession of nursing, and activities for the protection and advocacy of patients.

administrators meet together to assess the needs and demands of the public for the best in nursing care and then plan for academic programs that will produce the best educated and most skilled practitioner of nursing. Although the profession has not completely eliminated the educator-provider debate, the efforts of the nursing organization have brought the two sides closer than ever before.

Like most service professions, nursing has long had the debate between educators and service providers as to what the practitioner of the profession should know and do.

Politics and government are dirty words to most people, but nurses learned long go that it is in the political arena where decisions are made daily about the who, where, what, and how of health care. To make sure that the interests of Georgia nurses and its citizens are protected and represented when these decisions are made, GNA established its **Governmental Affairs Cabinet.** This arm of the organization educates nurses about the political process and encourages individual nurse-involvement; meets with individual legislators and government representatives to provide information about the profession and the impact of legislation, regulations, or pending decisions; or suggests legislation that will improve or protect the health and well-being of Georgia citizens. GNA has worked for legislation related to seat belts, motorcycle helmets, living wills, informed consent, nurse-protocols, reducing infant mortality, funding crippled children's programs, day care for Alzheimer's patients, funding for treatment and research of AIDS, and much, much more.

New knowledge and improved technology in any area comes through research which seeks answers to old questions, creates new questions, or simply establishes evidence that something is or it not true. That is the basis for the **Cabinet on Research in** GNA. These nurses look at every area of nursing, from the simplest bedside care technique to the latest educational computer program in order to analyze, study, and make recommendations about the future practice of nursing.

The arm of the association that has established GNA as a labor union under the rules of the National Labor Relations Board is the **Cabinet on Economic and General Welfare.** Although this program has probably created more fear and negative publicity in non-members, it is *not seen* by members as the most important association activity. To be sure, nurses have been and still are concerned with salaries, working conditions, and staffing patterns, but they give far more consideration to the quality of patient care and the abilities of those providing the care. Unlike other unions, GNA does not campaign to serve as the labor representative for nurses in any agency; but *when requested,* the organization will provide advice, consultation, and representation to nurses who need assistance.

The Georgia Nurses Association offers a meeting ground for debate and discussion on issues in the profession, and through the strength of group solidarity, can make a difference for an individual patient or the health care system as a whole.

GNA provides variety and diversity in a membership made up of nurses from all specialties who care for patients of all ages from prenatal to death. The organization offers a meeting ground for debate and discussion on issues in the profession, and through the strength of group solidarity, the individual nurse is empowered to make a difference for an individual patient or to impact the health care system as a whole. ■

Focus on Education: The Georgia League for Nursing

Karen Bacheller

THE GEORGIA LEAGUE for Nursing is the area constituent league of the National League for Nursing (NLN).

NLN's individual members include nurses, consumers, educators, researchers, administrators, and other health care professionals, totaling some 18,000. The League's agency membership comprises approximately 2,000 nursing education programs, home care and community health agencies, and nursing departments in hospitals and related facilities.

As part of the organizational structure of NLN, the Georgia League for Nursing is part of the Council of Constituent Leagues. This council serves as the national forum where constituent leagues may exchange ideas, discuss action taken and problems encountered, and make recommendations. It provides guidance and direction to the membership and advises the Board of Governors of NLN.

Upon joining NLN, individual members are members of the Council of Constituent Leagues in this area, the Georgia League for Nursing, and at least one other council usually related to their area of employment. The other councils are:

- Council of Associate Degree Programs
  Develops and improves associate degree programs in nursing to allow them to make approximate contributions, so that the nursing needs of the public are met.
- Council of Baccalaureate and Higher Degree Programs
  Develops, improves, and represents baccalaureate and higher degree programs.
- Council of Community Health Services
  Provides leadership and assists community health agencies in the development and improvement of their service programs.
- Council of Diploma Programs
  Develops and improves the diploma programs in nursing and exercises leadership in sound planning and advancement of diploma education in nursing.
- Council of Nurse Executives
  Provides opportunities among members who hold executive responsibilities in their employment settings to exercise leadership by assessing needs for leadership, developing an agenda, and identifying strategies for meeting those needs.
- Council for Nursing Informatics
  Creates a multidisciplinary network for assessing needs, providing information, and presenting programs on the impact of the information age and computer technology upon nursing.
- Council for Nursing Centers
  Promotes development of nursing centers as sources of affordable quality health care and a network for nurses who offer nursing services directly to consumers.

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Thousands of participants earn Continuing Education Units each year through NLN workshops and seminars held on academic, clinical, administrative and public policy topics.

- Council for Nursing Practice
  Continually develops and improves nursing practice.
- Council of Practical Nursing Programs
  Develops, improves, and represents programs leading to a certificate or diploma in practical nursing.
- Council for the Society for Research in Nursing Education
  Improves education in the practice and academic settings through the development, dissemination, and use of research and theory in nursing education.

The Georgia League for Nursing advances the promotion of health and the provision of quality health care within the changing health care environment of the state of Georgia by promoting effective nursing education and practice through collaborative efforts of nurses, consumers, representatives of relevant agencies, and the general public.

This mission statement is patterned after NLN's. Through NLN the following services are available to enhance this statement.

Accreditation

NLN is recognized by the U.S. Department of Education and by the Council of Postsecondary Accreditation as the official, national accrediting agency for nursing education. Currently, the number of NLN-accredited associate, baccalaureate, and higher degree programs, and diploma and practical nursing education programs is over 1,450. NLN also sponsors an accreditation program for community health and home care agencies, assuring consumers that an agency meets national standards and responds to the health needs of the community.

Consultation and Continuing Education

Consultation services are available from the NLN in many educational and management areas. The test service division provides consultation in test development and administration; the community health/home care division supplies both agencies and consumers with information and counseling. One of NLN's councils, the Council for Nursing Informatics, has instituted a consultation bureau specializing in computer technology for nursing. Thousands of participants earn Continuing Education Units each year through NLN workshops and seminars held throughout the country on academic, clinical, administrative, and public policy topics.

Testing

A major provider of testing programs and services for the nursing community, the NLN Test Service develops and administers pre-admission, student achievement, proficiency in practice, and educational mobility testing programs for a variety of nursing education and nursing practice settings. It also has consultation services on test development, use, and workshop planning.

Research

A primary source of statistical data on nursing education, trends, and personnel supply, NLN conducts several annual statistical surveys that are widely utilized by the nursing community, the government, health care agencies, and the media. Apart from the research department, NLN's Council for the Society for Research in Nursing Education works to define and improve nursing education through scientific investigation and theory development.

Communications and Public Policy

As a leader in the nursing community, NLN is often called upon to provide information and testimony to various governmental bodies and maintains a vigorous presence in the nation's capital to make sure that nursing contributes its voice to policy formulation that affects the delivery of health services to all citizens. As part of this process, NLN works to keep nurses and other health care providers active and up-to-date on health care legislation and regulatory issues.

Many of NLN's publications and videos focus on policy topics, particularly relating to education, research, and economics. NLN also publishes a wide range of management guides, reference materials, evaluation tools, information pamphlets, and student texts. *Nursing & Health Care,* a referred journal published 10 times a year, is the official publication offering the latest NLN news as well as provocative articles on issues facing nursing education and practice.

The Georgia League for Nursing (GLN) holds its annual meeting and educational program every February. During the year, the Board of Directors and various committees conduct the business of GLN.

NLN holds its national conventions every 2 years. At these conventions, policy is set for the National and Georgia Leagues for the coming years.

As we enter the 90s, the policy issues focus on the loss of health and social policy, losses that threaten the very social fabric of the nation. The memberships have directed NLN, and on a local level, GLN, to work toward the development of a national health plan and to address the mounting public health problems such as homelessness, AIDS, and care for the indigent. In addition to these items, work continues on the opposition to the RCT, creating an alternative in the community college setting, advancing human caring as a public agenda, adhering to standards for handling infectious waste, working toward elimination of tuberculosis, and supporting greater access to nursing services.

All of these issues will be worked on with the valued input of the consumer and other health care professionals. The membership of consumers and their input are one of the unique aspects of NLN and GLN. This aspect truly allows for the promotion of health and the providing of quality health care, not only in Georgia, but in the nation as a whole. ■

The Nurse Specialist: A Cornerstone of Quality Patient Care

Martha Ford, R.N., M.N., C.C.R.N.

History

In the early part of the 20th century, segregation of patients by illness became commonplace and may have been the initiating factor in the move toward specialization in nursing.[1] Other factors contributing to the development of speciality practice included the vast body of knowledge brought about by technologic and medical advances following World War II and the concept of division of labor for more efficient patient care. Prior to World War II, nurses were primarily employed in public health, hospital general duty, or private duty cases.

The move toward specialization in medicine intensified following the Second World War. Standards for and regulation of physician specialists was achieved in the 1930s when the system of certification by specialty boards grew from the AMA's concern that unqualified physicians were practicing as specialists. By the 1950s, the percentage of medical students planning to become specialists rose by 34% in a Cornell University study. The study reported students as feeling that medicine was too large for physicians to be confident in their practice unless they knew a great deal about one field, rather than a little about all areas.[2] In the 30 years since that study, quantum leaps in knowledge and technology have occurred in medicine and simultaneously, in nursing, making the fields of study exceedingly larger.

In 1972, the American Nurses Association and 12 specialty groups formed the National Federation of Nursing Specialty Organizations to serve as the vehicle for unity and communication between the specialty organizations and the ANA.

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Defining Nurse Specialists

The American Nurses Association (ANA) defines a nurse specialist as a nurse who has achieved "expert status in a defined area of knowledge and practice in a selected clinical area of nursing through supervised practice and study at the graduate level." Additionally, the ANA states that the specialist "should also meet the criteria for specialty certification upon completion of a graduate degree in a university graduate program with an emphasis on clinical specialization."[3]

The earliest nurse specialists were anesthetists, midwives, industrial nurses, and public health nurses. The first graduate program for psychiatric nurse specialists was founded in 1954.[1] In the 1960s, another growth of specialization occurred when coronary care units and other critical care special units

emerged. The expansion of critical care units has continued through the 80s, with the focus on specializing within the specialty. Some critical care units are combined, caring for more than one medical specialty. However, the trend seems to be toward segregation of critical care patients by speciality, e.g., cardiovascular, neurologic, pulmonary, etc.

Specialty Nursing Organizations

Nursing specialties can be grouped into three general categories: clinical setting (OR, ICU), patient age (pediatrics, geriatrics), and clinical disorders (neurology, urology). Specialty nursing organizations have followed patient care specialization because nurses needed to obtain more knowledge about their particular clinical area to establish forums for discussing patient care management issues, and to develop journals to present current knowledge of rapidly changing medical-technologic environment.[4]

In 1972, the American Association of Critical-Care Nurses (AACN) initiated dialogue among specialty groups at the First National Congress in Nursing at the Western White House in San Clemente, California. Later that same year, the ANA and 12 specialty groups formed the National Federation of Specialty Nursing Organizations (NFSNO), to serve as the vehicle for unity and communication between the specialty organizations and the ANA.[1]

Today, the NFSNO represents more than 360,000 nurses in over 35 specialty nursing areas. Many specialty organizations, including AACN, the Oncology Nursing Society, Emergency Nurses Association, International Association of Enterostomal Therapists (IAET), and the Association of Operating Room Nurses, maintain their own certification corporations. Just as physician specialists become board certified to assure competency, nursing specialty organizations are seeking to protect the public though a similar process.

Currently, AACN is the largest specialty nursing organization in the nation, with more than 63,000 members. The current number of certified critical care nurses (CCRNs) exceeds 30,000. Certification is achieved through a standardized process requiring a minimum of 1 year's critical care experience and successful writing of an exam covering all body systems and the psychosocial and legal aspects of critical care. In order to maintain certification, the CCRN must provide a minimum number of direct patient care hours and 100 hours of approved continuing education over a 3-year period. Each certification organization determines the requirements for achieving and maintaining certification in that specialty.

Specialty nursing organizations have followed patient care specialization because nurses needed to obtain more knowledge about their particular clinical area, to establish forums for discussing patient care management issues, and to develop journals to present current knowledge of a rapidly changing medical-technologic environment.

Enterostomal therapists provide specialty care for a variety of low-tech patient care problems. The IAET is a relatively small organization with less than 2,000 members, yet the impact of the care provided by this specialty group is dramatic. ETs provide expert consultation to health care providers not familiar with ostomy care, teach patients self care, and monitor the environment for improved products for patients. The IAET response to the Health Care Financing Administration (HCFA) attempts to regulate ostomy appliances for patients through arbitrary reimbursement mechanisms was to convince the organization that they were experts who could best make those decisions. With a grant from Johnson and Johnson, IAET conducted research which provided HCFA with scientific information about the utility of ostomy devices. The results provided patients with quality products at less cost. HCFA accepted their research findings and recommendations, and IAET members now serve in an advisory capacity to the government organization for product evaluation.

Health Care Environment

Prospective reimbursement and DRGs have dramatically changed the health care environment over the past 5 years. Budget-driven changes in medical practice and patient care delivery have resulted in shortened hospital stays and discretionary admission practices. Patient care must be compressed into a shorter time frame without diminishing quality. Expert nurses are able to observe, anticipate, plan, and organize care to accomplish satisfactory patient outcomes and facilitate early discharge. Attaining expert status is far easier for nurses who specialize in one clinical area.

Home health care is a new industry precipitated by early discharge practice. Ventilator patients, not previously eligible for transfer from a critical care unit to a medical-surgical floor, are now sent home. Terminally ill oncology and AIDS patients who require intravenous chemotherapy are managed at home with sophisticated infusion pumps, central lines, and drugs. Clearly, specialists are need not only to care for patients, but also to teach families to care for the patient during interim periods when no health care professionals are present.

Patients admitted to the hospital are, in general, more seriously ill than in the past. Predictions for the future suggest that hospital care will be available only for the critically ill. Therefore, the demand for acute care nurses will accelerate if these predictions become fact. Currently, the greatest area of nursing shortage is in critical care, because demand is outstripping supply.

Impact on Patient Care

AACN conducted a demonstration project over a 3-year period to determine the effectiveness of critical care units. This landmark study showed that care delivered by expert critical care nurses reduced mortality and was cost effective. Charges to patients for ICU care were 11% of their total hospitalization, far less than the 18% reported by Medicare. Patient mortality was 50% less than predicted.[5]

A 1985 study conducted by Dr. William Knaus at George Washington University showed a significant decrease in predicted mortality of ICU patients in units where physicians and nurses maintained collaborative professional relationships. None of the other factors, including size, physician resources, administration, etc., were statistically significant. Knaus and his group established an evaluation system based on physiologic indicators from which critical care patient outcomes could be predicted.[6]

Anyone who spends time in a health care institution can verify the efficiency of patient care rendered by nurses who are expert in their clinical area. An analogy can be made to having an orthopedist rather than a general surgeon perform a total hip replacement. The outcome will certainly be superior if for no other reason than it will take an orthopedist less time to perform the procedure.

Specialty Nurses in the Future

Nursing education has traditionally been directed toward producing generalists, with the expectations that specialization will occur at the graduate level. Specialization at the undergraduate level is not an unreasonable goal, particularly in the face of the changing health care delivery system. Nursing education and service will share the burden of preparing men and women for the changing roles of nurses and increasingly sophisticated nursing practice. New theories, techniques, and skills are necessary to meet the needs of a complex, dynamic, and highly technologic society. Specialy nursing care is a rational means of meeting that challenge.

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The Nursing Shortage: Central Georgia's Rx

Damon D. King, F.A.C.H.E.

The main objective of the Task Force was to stimulate awareness of nursing as an attractive career and to generate an increased number of qualified applications to the nursing program.

THE SHORTAGE of nurses has created a crisis among healthcare providers throughout the state of Georgia. According to a 1987 University System of Georgia study, there were approximately 3,000 vacancies for nurses, but only 1,500 graduates of state RN training programs to fill those slots. An out-of-date image of nursing as "women's work" or "handmaid" to the physician, increasing opportunities for women in fields previously dominated by men, and pay which has not adequately recognized such factors as changing schedules, night, evening, and weekend work had prompted many academically able students to reject nursing as a career option.

This serious dilemma forced us to pose an equally serious question: how can we reverse this trend and create new interest in the profession? The Medical Center of Central Georgia, Macon College, and eight other area hospitals have found an answer.

In the summer of 1987, Dr. Aaron Hyatt, the president of Macon College, suggested that administrators and marketing/public relations representatives from The Medical Center, Charter Lake Hospital, HCA Psychiatric Hospital, Middle Georgia Hospital, Charter Northside Hospital, Houston Medical Center, Monroe County Hospital, HCA Coliseum Medical Center, and Peach County Hospital form a Marketing Task Force on Nursing. Dr. Hyatt had no idea what a tremendous, positive impact his idea would have.

Within the first year alone, applications to the Macon College Associate Degree in Nursing program increased 146 percent, and 140 new students were accepted, almost twice the number accepted the year before. In the fall of 1989, 282 students were enrolled, making it one of the largest nursing programs in the state. Macon College expects to graduate 115 new RN candidates in the spring of 1990 — its largest class ever. In addition, approximately 650 students are in the process of completing their pre-nursing requirements.

The main objective of the Task Force was to stimulate awareness of nursing as an attractive career and to generate an increased number of qualified applications to the nursing program. Our long-term goal was and remains to increase the number of qualified nurses

Mr. King is President of The Medical Center of Central Georgia.

Send reprint requests to Ms. Jacquie Pfeiffer, Marketing/PR, Hospital Box 153, Medical Center of Central Georgia, P.O. Box 6000, Macon, GA 31208.

available for hire by local hospitals. The campaign has been funded by Macon College and the nine hospitals, whose contributions are based on their number of licensed beds.

The Task Force's initial meeting saw the formation of two sub-committees — one to look at the feasibility of sponsoring an educational program for high school guidance counselors and a second

Although this campaign was initiated only a year ago, results are already evident. The number of incoming juniors doubled to 96 in the fall of 1989, giving Georgia College one of the largest BSN enrollments in the state.

to explore the potential of an advertising campaign aimed at increasing public interest in nursing careers.

We determined our primary target market, males and females between the ages of 18 and 24, and our secondary target market, males and females between the ages of 25 and 49. Recruiting efforts were aimed at recent high school graduates and "non-traditional" students, those 25 years or older who didn't go to college right after high school. After several years, with their children now in school, they have the time and want to go to college and pursue a career.

With this in mind, two recruiting brochures and radio and television spots were planned. We received tremendous support from the local media. One radio station produced our spots at no charge, and all stations that aired our spots gave us a

Macon College's readiness to adapt to unique situations has also contributed to our successful effort. An evening program for students who cannot make the day classes was initiated in the fall of 1989.

discount or assisted with public service announcements. The efforts of the Task Force also received publicity in newspaper editorials, a full 30-minute slot on a community talk show, and coverage by several local newscasts. A local advertising agency helped with the planning and production of the brochures at a greatly reduced price. There was a strong commitment to the project on the part of everyone involved.

A high school counselors' luncheon featured testimonials on the rewards of nursing from practicing RNs, information on the admission standards of the Macon College nursing program, and financial aid programs available to nursing students. Fifty counselors attended, each accompanied by a hospital administrator or nursing recruiter who answered questions and offered personal attention.

The seminar, "So You Want To Be A Nurse," which is held on a quarterly basis, attracted over 300 graduating high school students and non-traditional students, double the number that attended the same program the year before, and five times the average attendance over the past several years. The seminar continues to draw a large crowd.

The campaign prompted quite a few students to change their majors, and enrollment in the Macon College LPN Mobility Program increased. This program allows LPNs who have been in the workplace to take a department challenge examination and one bridge course which, if successfully completed, qualifies them to enter the RN program with sophomore status. For these reasons, a larger number of nursing graduates was expected in 1989. However, because the campaign concentrates primarily on new students who must complete the entire 2-year sequence, the largest and most notable increase is expected in the spring of 1990.

Macon College's readiness to adapt to unique situations has also contributed to our successful effort. An evening program for students who cannot make the day classes was initiated in the fall of 1989. Not only does it give students greater flexibility, but allows the school to expand the limits of its nursing program. Four additional nurse educators have been hired to handle the increase in students. Two of these positions were created with special initiative funds granted to the University System by the Georgia Legislature. Additional faculty positions will be created as the program grows and the number of students increases.

This is an on-going campaign. Hospital administrators now meet periodically to review the situation, reaffirm our commitment to the program, and come up with new ideas.

The idea has caught on. The success of the Marketing Task Force on Nursing with Macon College prompted the formation of a similar group in cooperation with the nursing department of Georgia College in Milledgeville. It includes The Medical Center, Baldwin County Hospital, Charter Lake Hospital, HCA Psychiatric Hospital, Middle Georgia Hospital, Charter Northside Hospital, Houston Medical Center, and HCA Coliseum Medical Center.

The Georgia College Task Force on Nursing first met in November 1988 and recruitment efforts began the following January. The campaign included newspaper, radio, and television coverage, plus special forums and a high school guidance counselors' luncheon.

Although this campaign was initiated only a year ago, results are already evident. The number of incoming juniors doubled to 96 in the fall of 1989, giving Georgia College one of the largest BSN enrollments in the state. New staff positions, funded by the participating hospitals and the state of Georgia, were created to accommodate the additional number of students.

There are currently about 400 students in the School of Nursing. The program has the lowest attrition rate in the state, graduating 92 to 93 percent of its students. In addition, 97 percent of Georgia College nursing students passed their state board exams last year — one of the highest percentages in the state.

The tremendous success of these campaigns validates one of my very strong beliefs concerning the nursing shortage. I believe there are many people in our community and across the country who would love to be a nurse and who are perfectly capable of completing the academic requirements. They simply have not been informed of the opportunities available and shown a way to get the funding for their education. We have made sure our campaign stresses that scholarships and loans are available.

The idea has caught on. The success of the Marketing Task Force on Nursing with Macon College prompted the formation of a similar group in cooperation with the nursing department of Georgia College in Milledgeville.

Initially, 90 percent of Macon College nursing graduates and 95 percent of Georgia College nursing graduates take jobs in Central Georgia, and most remain in the area. This means our community will get relief very soon. I believe this type of task force could produce similar results in other cities. If other communities across the country would implement a campaign such as this, we would see the nursing shortage begin to correct itself very quickly.

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The Nurse and the Physician

G. Y. Moore, M.D.

MADAME PRESIDENT, guests, and members of the Georgia State Nurses Association, I bring you greetings from an older member of the great healing family of our State, the Medical Association of Georgia. As its President and official representative I am glad to be present and to attest to the friendly, cordial relationship which is and always has been first expressed and, most typically, between the physician and nurse at the bedside — but also by an arrangement whereby you have become a part of the public information service of the official organ of the Medical Association of Georgia through the pages of the *Journal* of the Association in which we voice your policies and purposes as though they were our own. This implies the confidence our Association has in yours. For a number of years your official representative has been invited to meet our House of Delegates to lay before it for endorsement or edification such matters as seem fit to your body. This exchange of interest and information must bring us closer and in great understanding of our mutual service and of our mutual aims in the care of the sick.

For all these the remedy is education, education of the young woman who desires to become a nurse in the high school in requiring home nursing courses . . . , education of the community to take the responsibility of organizing and sponsoring community registries. . . .

Dr. Moore, from Cuthbert, was president of MAG in 1930. This is his address before the 24th Annual Session of the Georgia State Nurses Association in Atlanta on October 27, 1930. Reprinted from the December, 1930, issue of the *Journal of the MAG.*

Georgia is a rural state, and its problems in the care of the sick are complicated because of political divisions, highway problems, race relations, economic stress, professional personnel or rather lack of it.

By a strange coincidence, perhaps, you have chosen your president from the rural community and the physicians have chosen their president from the same community. It gives me pleasure to have the opportunity to attest to the devotion in all kinds of trying circumstances, in the country districts of the private duty nurse with whom I have had most of my experience. Your President and I have had long and most pleasant relationships. To her and to those of your number like her I wish to pay tribute.

Much of my active practice has been spent in the rural districts where there was neither hospital nor nurse to assist.

I have had a long apprenticeship in practical nursing myself and perhaps some conclusions I have come to would be far different. With some of these conclusions you will be in accord, with others you may

differ. If so, ascribe to them sincere good fellowship and the best of motives, at least.

The nurse has been the greatest single aid to the physician in his services to mankind.

In the words of Dr. J. Chalmers Da Costa, the famous surgeon of Philadelphia, in a notable address before the ex-resident physicians of the Philadelphia General Hospital, while speaking of the inmates of that great institution and dumping ground for suffering humanity, adds this striking statement. "Here are some who seek health, and some who wish for death. Here comes the physician to heal and to teach, and the student to observe and to learn. Here comes charity to relieve, and religion to console and the foul blight of municipal politics to annoy, to hamper and to curse; and here among some of the worst men living and the most unfortunate, comes woman, white capped and cheerful to comfort and to bless." So comes the trained nurse ever in hospital and home, blotting out the pictures of the dark past. So came and went in the very halls of the great hospital referred to one of your own great leaders, your late National President, Miss S. Lillian Clayton. Loved and honored and acclaimed as having done most in a practical way to symbolize nursing, she was awarded posthumously the first Saunder's Medal.

Medicine has been subject to great changes in practice and preparation. As its sister profession nursing is also passing through a period of rapid growth and transformation which is inevitable.

Unlike it, however, it finds its problem more complicated because of such wide divergence in schools, curricula, length of training and most of all in the opinions of what a nurse should be taught.

W.A. Newman Dorland of Chicago, one of the distinguished surgeons of the country, quotes as to the definition of the functions of a nurse as follows: "To care for the bodily needs of the patient; to carry out the physician's order; to keep a careful record of the happenings of the sick room as regards the vital phenomena of the patient. Everything that the nurse needs to do and know may be grouped under one or another of these functions, and any teaching that contemplates anything beyond this would merely burden the nurse with useless theory or inspire her with the erroneous and fatal ideal that she is endowed with the knowledge and skill of the medical attendant." He goes on himself to add, "if this is all that will be expected or required of her is it necessary for any woman endowed with the average gifts of brain and common sense to spend three or four years acquiring a nurse's diploma?" If I may interpret the last sentence of the definition I greatly differ with his conclusion. Dealing with the "sickroom as regards the vital phenomena of the patient" (in the vernacular) takes in a lot of territory.

Nursing finds its problems more complicated because of such wide divergence in schools, curricula, length of training, and most of all in the opinions of what a nurse should be taught.

I take it, it is what Florence Nightingale meant when she said a nurse comes to do away with all the discomforts, all the irritations, apart from the particular malady from which the patient may be suffering. To do this she meets a broad educational foundation in physics and chemistry, and physiology, and hygiene, in literature and history, in sociology and psychology. This does not in any sense minimize the greater need of innate refinement, common sense, the keenest perception and good judgment, those qualities indispensable to the making of wise decisions, the development of self control, and the establishment of confidence.

The nurse of the older group excelled in these qualifications, perhaps because she was more individually chosen, and trained individually at the bedside as cannot so well be done in the modern school except at relatively prohibitive cost in supervisory personnel.

There is where it seems to me lies the advantages of the school in the small hospital. Is there not some plan or could not one be devised where this great advantage might be kept at little or no sacrifice to the best interests of preparations? Some form of centralized courses of instruction with extension courses in the small hospital could carry out this idea.

Let us all work for it in Georgia!

You are passing through a great crisis in your professional advancement.

The work of the national grading committee has pointed out deficiencies in your preparation and schools, bad organization in the distribution of your services, economic stress in the rank and file of your personnel. For all these the remedy is education, education of the young woman who desires to become a nurse in the high school in requiring home nursing courses which will disclose aptitudes and lead to vocational guidance education of the community to take the responsibility of organizing and sponsoring community registries and distribution of the cost of sickness, risks to the whole community instead of to those alone who are ill and who wait to serve them.

The Medical Association of Georgia stands ready to support you in the future as it has in the past, to endorse such measures as lead to better and more nursing care to more of our people, and to assist you in establishing a higher ethical performance of your duties, and more satisfying personal rewards in their doing. ■

Supreme Court Expands Physician Rights in Composite State Board Proceedings

Robert N. Berg

THE GEORGIA SUPREME Court recently rendered an opinion which, in practice, should serve to expand the rights of physicians in licensing proceedings brought by the Composite State Board of Medical Examiners ("Board"). Depending on one's viewpoint, this case may be "good news" or "bad news": Good news to physicians being investigated by the Board, who may now appeal decisions by the Board, in certain cases, prior to the completion of the Board proceeding, and who may also, under certain circumstances, discover the identities of persons providing information to the Board; bad news to physicians and other persons who might provide information to the Board, as they no longer may be assured that the information can be provided to the Board in confidence; and, lastly, bad news to the Board, which now may be faced with far more lengthy proceedings, and perhaps with fewer proceedings, as a result of the Board's inability to provide assurances that the identity of complainants will be kept confidential. This interesting case is the subject of this month's Legal Page.

"The Board may now be faced with far more lengthy proceedings, and perhaps with fewer proceedings, as a result of its inability to provide assurances that the identity of complainants will be kept confidential."

Rights of Appeal in Board Proceedings

In *Wills v. Composite State Board of Medical Examiners*,[1] the Board brought formal charges against a Georgia physician, following an investigation. During the course of this proceeding, prior to the scheduled hearing, the hearing officer conducted a pre-hearing conference at which, among other things, he upheld the Board's refusal to provide the physician under investigation with "records and written results of the investigation conducted by the Board; all investigation reports, witness statements, correspondence, and any other document, material, or audio tape or video tape which contains information which might be exculpatory or favorable to [the physician]; correspondence or documents in the Board's possession which requested or urged the Board to investigate or bring charges against [the physician]; *and names and addresses of the person(s) who made the complaint or accusation against [the physician] which resulted in the investigation and prosecution of [the physician] by the Board.*"[2]

The physician filed an interlocutory appeal (i.e., an appeal prior to the completion of the Board proceeding), asking the trial court to reverse the Board's refusal to provide the physician with the request information. The Board defended on the grounds that the physician had failed to exhaust administrative remedies, inasmuch as there had not been a final decision in the Board proceeding. The Board's position was based upon certain statutory provisions in the Georgia Administrative Procedure Act[3] which generally provide that decisions of Georgia's agencies are not subject to appeal, until they are final. The Board also relied upon a series of judicial decisions, requiring the exhaustion of remedies within the particular agency involved (i.e., a "final decision" by the agency), prior to the filing of any judicial appeal.[4]

The trial court accepted the Board's analysis and held that the physician's appeal was premature.

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The Supreme Court reversed, however, finding that judicial review of the Board's preliminary procedural ruling was appropriate. The Court relied exclusively on a provision in the Georgia Administrative Procedure Act providing that a "preliminary, procedural, or intermediate agency action or ruling is immediately reviewable if review of the final agency decision would not provide an adequate remedy."[5] In the Court's view, the physician could not adequately prepare his defense because of the Board's refusal to provide the requested information prior to the hearing. This refusal, if incorrect, could cause irreparable injury to the physician, if the physician could not appeal this ruling directly to the courts, without first going through the remainder of the Board proceeding.

Disclosure of Information Concerning Board Informants

The Court then dealt with the Board's refusal to provide the physician with the identity of the person or persons who had initially complained to the Board. The Supreme Court commenced its analysis by noting the importance of understanding "the gravity of the situation [the physician] faces. The Board has the power to revoke [the physician's] license. Without his license, he will lose his practice, and without his practice he will lose his livelihood. The possible deprivation of the [physician's] license/livelihood requires constitutional analysis."[6]

The Court then analyzed the particular statutes involved, and found that they provided for the confidentiality of all information and records generated by the Board during an investigation, and prohibited the release of that information and those records, *except a release for the purpose of a hearing before the Board.*[7] Since the physician in the subject case was requesting the information for the express purpose of preparing for a hearing before the Board, the release of the information, according to the court, was not prohibited under the statutes. The Court also analyzed the relevant case law, and found that all of the previous cases had dealt with situations where the requesting physician had sought Board investigative records for a purpose other than a "hearing before the Board," and thus were not applicable in the subject case.[8]

"As the Board can no longer promise absolute confidentiality to its informants, this may have a chilling effect on the willingness of physicians and others to provide information to the Board."

Instead, the Court chose to liken a Board administrative proceeding to a criminal action, where, under well-settled case law, a defendant is entitled to access to any information or documents in the possession of the prosecutor which is "exculpatory, favorable or arguably favorable" to the defendant.[9] Thus, the Court held that "(a) licensee facing the possibility of the loss of a license/livelihood must, upon proper request, be allowed access to information held by the Board that is exculpatory in order for the application of the [Board hearing/appeal] statutes to reach a constitutional result."[10]

Impact of the Wills Decision

One significant impact of the *Wills* decision may be evidenced in the future course and length of Board investigative proceedings. As a result of the Supreme Court's decision to allow interlocutory appeals, it is likely that the length of time involved in a Board proceedings (from the commencement of the investigation through the completion of the Board hearing and any subsequent intraagency appeals) will be dramatically increased. This, in turn, may result in reducing the Board's ability to prosecute cases. As the Executive Director of the Board, Mr. Andrew Watry, recently noted, "The passage of time really hurts your ability to prosecute in a criminal setting. Cases lose luster over time. Six years later, you have less witnesses. If you can cork up the case long enough, you get lighter sanctions."[11]

Alternatively, it is possible that courts in future cases may limit the *Wills* case to its facts — a reflection perhaps of the Supreme Court's desire to reach the issue of the confidentiality of the identities of Board informants. If so, we may see future cases decided in a manner designed to restrict or cut back the interlocutory appeal rights of physicians in Board proceedings.

Perhaps an even more profound effect, resulting from the Supreme Court's decision in the *Wills* case, relates to the Board's ability to obtain initial leads and information from complainants. Essentially, the Board can no longer promise absolute

"The entire physician community, as well as the general public, may be worse off if the Board is significantly impeded in its ability to prosecute physicians who fail to comply with the State's licensing standards."

confidentiality to its informants; this may have a chilling effect on the willingness of physicians and others to provide information to the Board. Moreover, it may place the Board in the position of having to rely more upon anonymous witnesses who are unwilling to disclose their identities to the Board, for fear of disclosure to the physician being investigated. This may resulting in hindering Board investigations and prosecutions, to the extent that evidence from anonymous witnesses may be viewed as less credible than evidence from witnesses willing to disclose their identities.

Conclusion

It is unclear at this point who are the true winners and losers as a result of the *Wills* decision. Certainly, physicians are better off when courts act to protect their constitutional rights. By the same token, the entire physician community, as well as the general public, may be worse off if the Board is significantly impeded in its ability to prosecute physicians who fail to comply with the State's licensing standards.

Notes

1. _____Ga. _____, _____ S.E. 2d _____ (October 19, 1989).
2. *Id.*, _____Ga. at _____n.1.
3. O.C.G.A. §50-13-19(a).
4. *See. e.g., MacLafferty v. Department of Public Safety,* 230 Ga. 22, 195 S.E.2d 748 (1973).
5. *Wills, supra,* _____Ga. at _____.
6. Id., _____Ga. at _____.
7. *See* O.C.G.A. § 43-1-19(h) (2); §43-34-37(d).
8. *See, e.g., Morton v. Skrine,* 242 Ga. 844, 252 S.E. 2d 408 (1979); *Rogers v. Composite State Board of Medical Examiners,* 245 Ga. 364, 265 S.E.2d 1 (1980).
9. *See, e.g., Brady v. State of Maryland,* 373 U.S. 83, 83 S.Ct. 1194, 10 L.Ed. 2d 215 (1963).
10. *Wills, supra,* _____Ga. at _____.
11. *Atlanta Journal,* November 27, 1989, page C-4.

QUOTES

There is a magic in the memory of a schoolboy friendship. It softens the heart, and even affects the nervous system of those who have no heart.
BENJAMIN DISRAELI

He is a wise man who seeks by every legitimate means to make all the money he can honestly, for money can do so many worthwhile things, not merely for one's self but for others. But he is an unmitigated fool who imagines for a moment that it is more important to "make the money" than to make it honestly. One of the advantages of possessing money is that it facilitates the maintenance of one's independence. The man head-over-heels in debt is more slave than independent. He cannot look others straight in the eye and carry his head at a self-respecting height. Without a reasonable sense of independence there cannot be experienced the most satisfying brand of happiness.
B.C. FORBES

To please, one must make up his mind to be taught many things which he already knows, by people who do not know them.
NICOLAS CHAMFORT

Wherever the art of medicine is loved, there is also love of humanity.
HIPPOCRATES

The fickleness of the woman I love is only equaled by the infernal constancy of the women who love me.
GEORGE BERNARD SHAW
The Philanderer, II, 1898

In their choice of lovers both the male and the female reveal their essential nature. The type of human being which we prefer reveals the contours of our heart.
ORTEGA Y GASSET

All are not friends that speak us fair.
JAMES CLARKE

It is a fact that great eaters of meat are in general more cruel and ferocious than other men; this observation holds good in all places and at all times; the barbarism of the English is well known.
J. J. ROUSSEAU: *Emile, I, 1762*

Morality in sexual relations, when it is free from superstition, consists essentially of respect for the other person, and unwillingness to use that person solely as a means of personal gratification, without regard to his or her desires.
BERTRAND RUSSELL
Marriage and Morals, XI 1929

Luck is not something you can mention in the presence of self-made men.
E.B. WHITE

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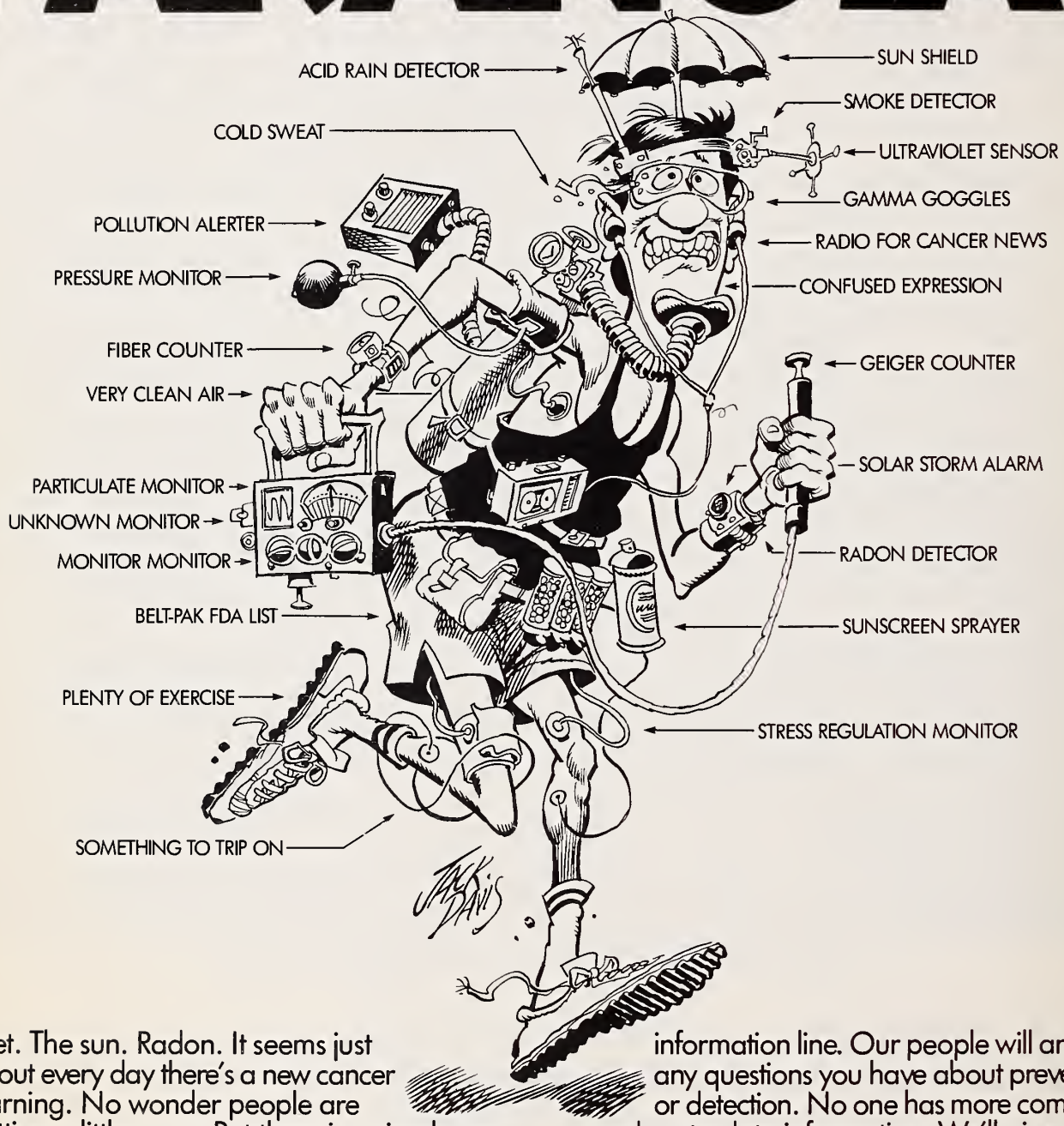

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MANUSCRIPT INFORMATION

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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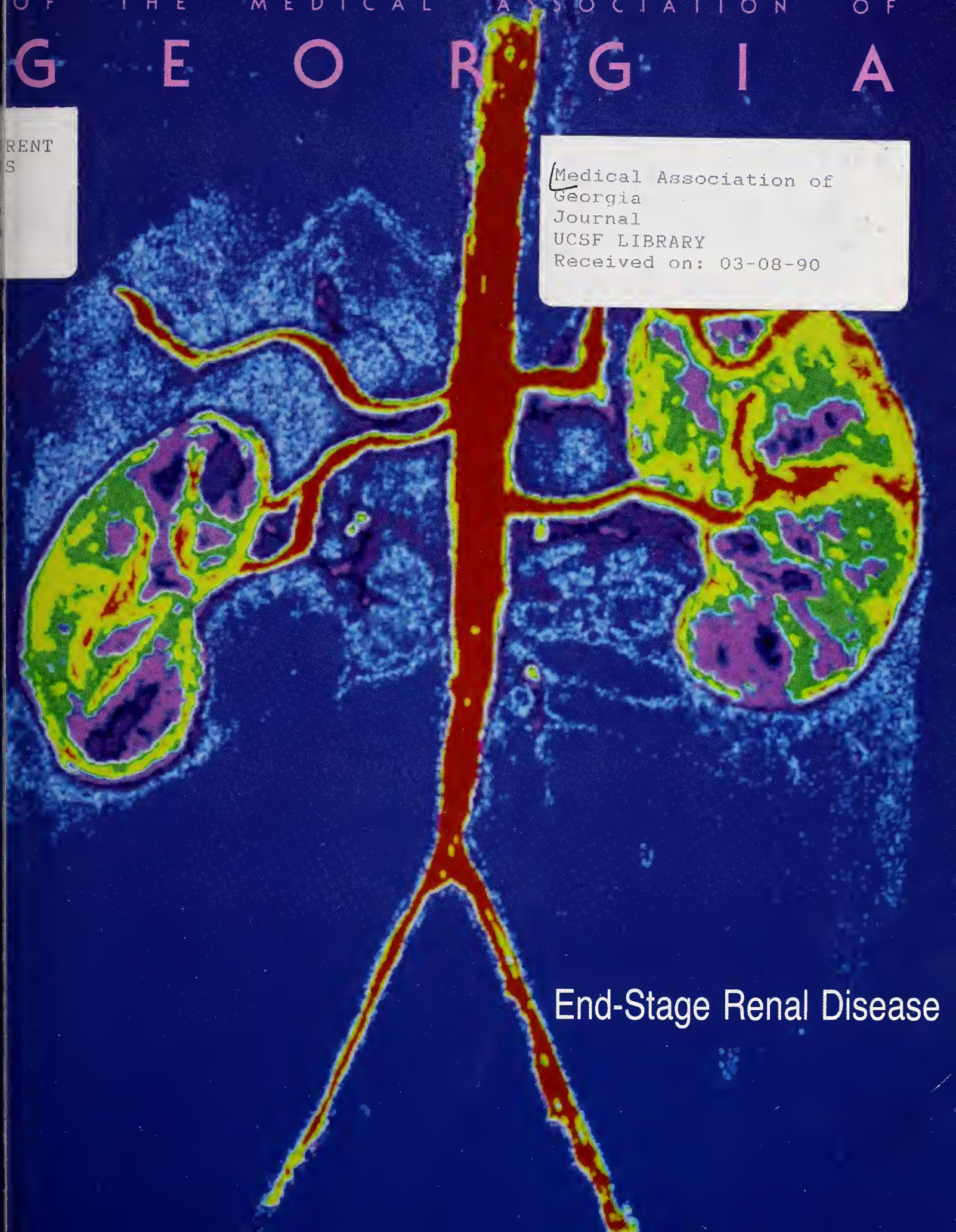

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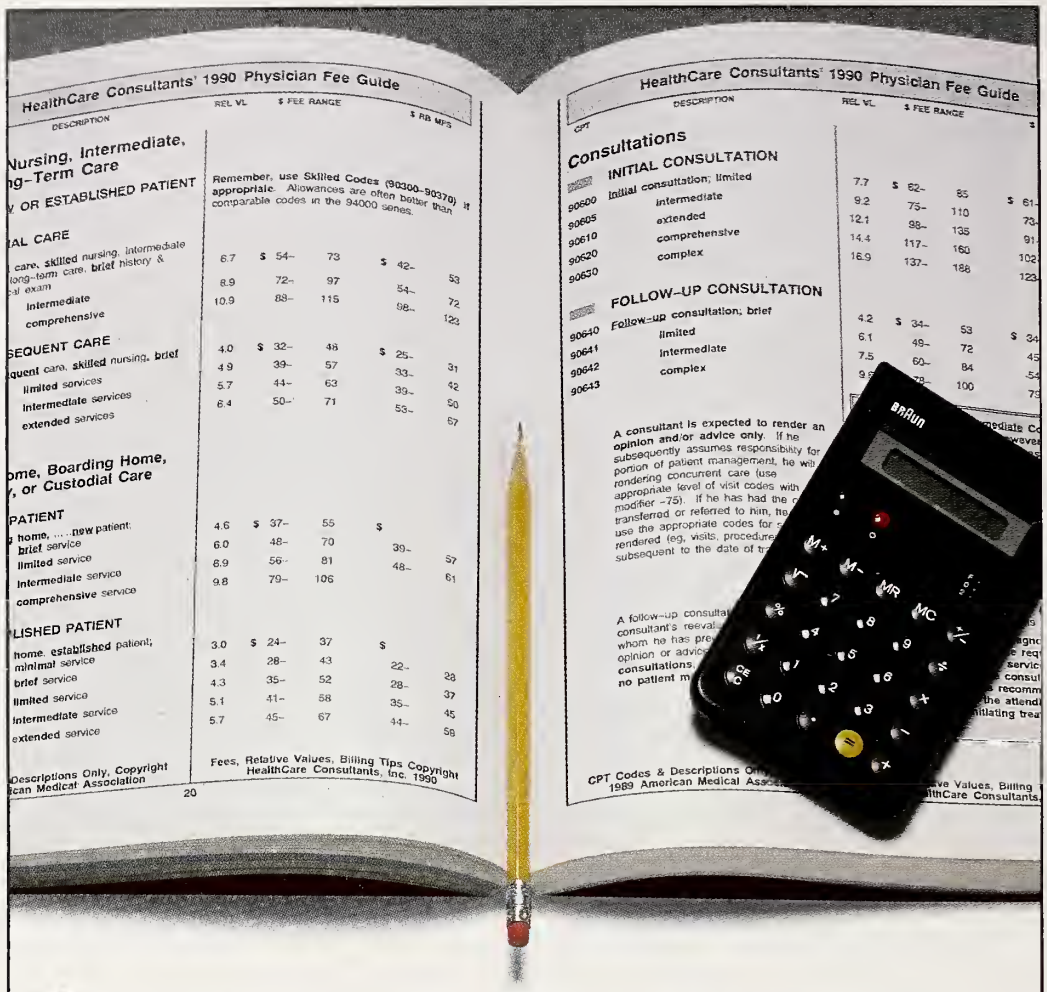

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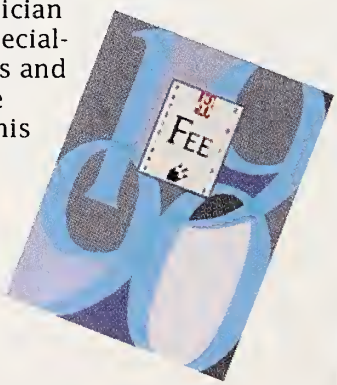

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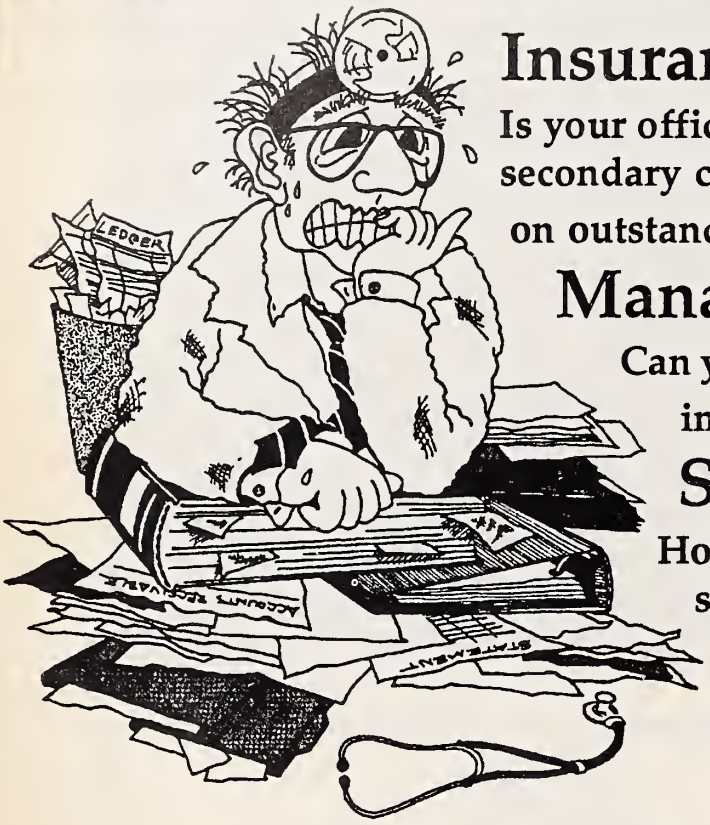

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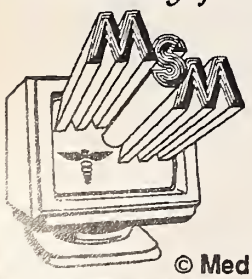

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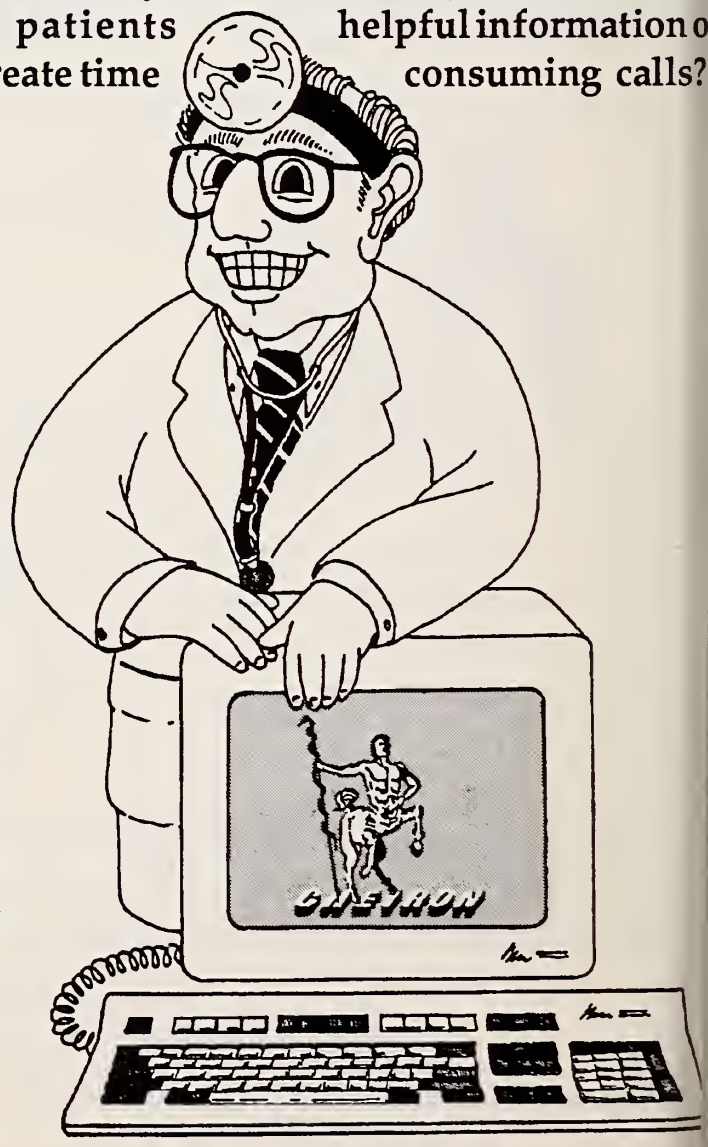

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THE COVER

Digital Subtraction Angiography (DSA) of diseased left kidney illustrates major disruption of blood supply to left kidney resulting in shrinkage of kidney. Tissue of kidney, lacking blood supply, hardens and toughens, and loses function.

Computer color enhancement of DSA image was accomplished on a Megavision 1024 computer. Photography by Howard Sochurek, of New York City.

Dear Editor,

The undersigned two general internists wrote an article published in the January 5, 1990, edition of the *Journal of the American Medical Association* entitled, "Applying Brakes to the Runaway American Health Care System." We have, gratifyingly, received many comments pro and con and wish to respond. The salient thrusts of the article are as follows:

1. For a variety of reasons, not the least of which is the astounding post World War II technological advances, the medical profession can furnish more health care than the nation can, or is willing to, pay for.

2. As the concept has settled over the country that health care is a right, silently attested to by the existence of the Medicare, Medicaid, and other programs, there has been no quantitation as to **how much** health care is a right.

3. To the **extent** to which health care is a right, that right, like all rights, will have to be guaranteed by the nation as a whole.

4. Since resources are not limitless, those rights will have to be prioritized, or more bluntly put, rationed.

5. The vast majority of the private sector health care expenses in the United States are paid for by Corporate America.

6. The last significant barrier between us and national health insurance is Corporate America.

7. Corporate America is reeling under the impact of current levels of health care expenses, and an increasing number of publications attest to the fact that discussions are being held by Corporate America regarding the possibility of national health insurance (i.e., the Kiplinger Washington Letter, January 12, 1990).

8. The federal government, the largest payer in the public sector, has legislated limits on its contribution to health care costs.

9. There are 37 million underinsured, largely uninsured, Americans. The expenses for these is largely being borne by the private sector through the mechanism of cost shifting by institutional providers. When these providers raise their rates to stay solvent, it doesn't affect the Fed but only those who have to pay billed charges, namely, the private sector. This has increased their burden to the breaking point. Therefore, we feel health care overtures will have to be contained in all sectors.

10. The only way to even reasonably equitably prioritize health care is through a national commission representing the private sector, the government, and humanities.

11. There will have to be developed a "basic health care benefits package" to which all Americans will be entitled either through their private insurance or, if they are public beneficiaries, the government. Any health care over and above this will be a negotiated option.

12. The intent of the article alluded to above, therefore, was to outline a mechanism for the creation of a national health care **policy.** It does not advocate national health **insurance**.

Nicholas E. Davies, M.D.
Louis H. Felder, M.D.

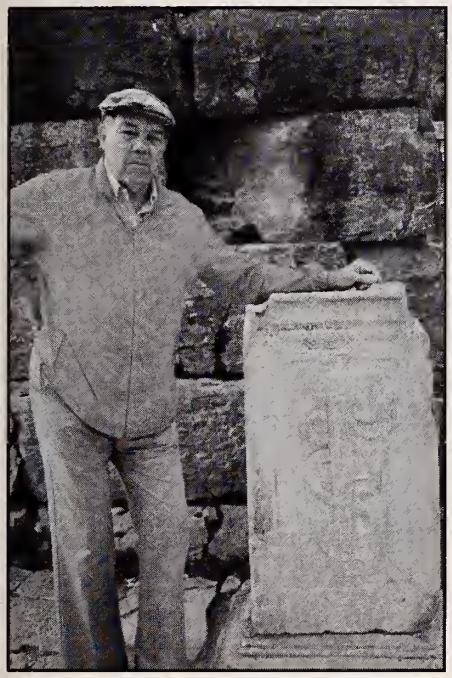
Dear Editor,

I greatly enjoyed the article by Ms. Lou Carver of the Spokane County Medical Society, "The True Symbol of Medicine: One Snake or Two?" in the [December, 1989], issue of the MAG *Journal.* Her account of the historic development of these symbols is probably as accurate as any, and there are a few variations.

One a recent trip to Greece and Turkey, my wife and I visited the temple of Aesculapius near Epidaurus. There we found the same spring with healing waters which had been used for well over 2000 years. One bald headed man in our party massaged his shining scalp with the magical liquid. I satisfied myself with a long cool drink strengthened with a shot of good old American bourbon from a pocket flask brought for just emergencies.

Later, while touring Ephesus, which in 200 B.C. was a very highly developed Greek Colony and is now in Turkey on the eastern Aegean Coast, our guide pointed out the marker and site of a shrine to Aesculapius showing the single snake symbol (see photo). He believed this marker to date from the second or third century B.C. Ephesus was later destroyed by earthquakes and raiders but is now being extensively excavated and studied by many archeologists — notably the West Germans.

I regret that we did not go to the isle of Cos — legendary home of Hippocrates. Even though I wore the caduceus of the Army Medical Corps on my uniform in World War II and still have a few souvenirs, I think I would now



Dr. John McClure standing next to a marker with a single snake symbol at the site of a shrine to Aesculapius in Ephesus on the Aegean coast.

side with the Air Force for one snake. After all, I am still somewhat of a traditionalist.

With kindest personal regards to all, I remain.

Sincerely yours,
John N. McClure, Jr., M.D.
Surgeon, Cumming

Dear Editor,

Re: "The True Symbol of Medicine: One Snake or Two?" *JMAG*, Dec. '89, p. 809.

The proper symbol for the medical profession is an ongoing debate. Whether we vote for Aesculapius' staff with one serpent or for Mercury's wand with two, we can hardly avoid a mixture of both emblems on items for professional or personal use. Confusion has reigned for centuries, and no disentanglement is in sight.

Truthfully, I don't think many doctors today are turned on by snakes, paganism, or complicated mythology (except in negative ways).

Could we be bold and come up with a new, more appropriate emblem? Perhaps MAG could spearhead a decision by our country and others to adopt a less problematic emblem.

If any creative folks can't wait for an official committee to decide about this, they can go ahead and draft the design they would like and mail it to me as unofficial custodian. May something admirable and inspiring come of this.

Hopefully yours,
Rebekah Y. Anders, M.D.
Riverdale

QUOTES

A rich man is nothing but a poor man with money.
W. C. Fields

Nature never intended man to be a low, grovelling creature. From the moment of his birth she implants in him an inextinguishable love for the noble and the good.
Longinus:
On the Sublime, XXV, c. 250

Mankind are very odd creatures: one half censure what they practise, the other half practise what they censure; the rest always say and and do as they ought.
BENJAMIN FRANKLIN:
Poor Richard's Almanac, 1752

Our sex's weakness you expose and blame,
Of every prating fop the common theme;
Yet from this weakness you suppose is due
Sublimer virtue than your Cato knew.
From whence is this unjust distinction shown?
Are we not formed with passions like your own?
Nature with equal fire our souls endued:
Our minds as lofty, and as warm as our blood.
MARY WORTLEY MONTAGU:
Letter to James Steuart, July 19, 1759

Quackery and idolatry are all but immortal.
O.W.HOLMES:
The Medical Profession in Massachusetts, 1869 (Lecture in Boston)

Each loves itself, but not itself alone,
Each sex desires alike, till two are one,
Nor ends the pleasure with the fierce embrace;
They love themselves a third time in their race.
ALEXANDER POPE:
An Essay on Man, III, 1733

Great men are not always wise.
JOB XXXII, 9, c. 325 B.C.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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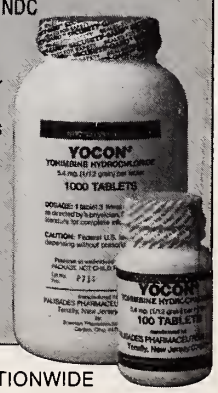

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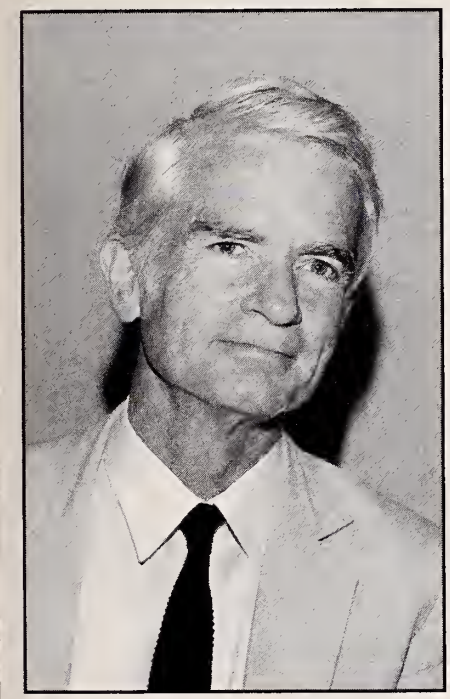

Joe L. Nettles, M.D.

Private vs. Universal Health Insurance

Last week, in the middle of my office hours, I received a call from London. It was from my son, Lee, a 3rd year Business Major at the University of Georgia who is participating in an exchange program with the University of London. After 6 weeks of didactic classroom work, he is doing an 8-week internship with a London advertising firm.

"Dad, I want you to send me all the material you can find on private health care insurance in the United States!" He then went on to explain that one of his advertising firm's chief clients was Summa, the largest private health care insurance company in England.

It seems that private health insurance is the big thing in England at this time. Many executives and other British citizens who can afford it are fed up with Universal Health Service. They do not want the long waits and the inferior product and are opting to go private — even though they have to pay extra. A two-tiered form of practice is developing in England. My son's advertising firm wanted him to compare private insurance with England's insurance system.

Today's medicine in the United States is under attack. No one disputes that it is the best medicine in the world — but its cost is considered by many to be escalating at an out of control rate. The enormous growth in health care technology during the past 30 years has not been accompanied by the ability and wisdom to control it. Various estimates are given as to when America will no longer be able to support its health care system. As Congress cuts back on its funding, private industry or state government is being asked to step in. Oregon, California, and New York are considering stop-gap measures that are revolutionary. Our national leaders are looking at other countries — England, Canada, Germany, and France.

If we do go to another model of health care delivery, we may find that we are taking a giant step backward. As we go into an era of peace, we may be able to shift some of our armament budget toward the care of the health of our citizens. After all — what could be more important?

However, if we are to retain our traditional form of medicine in the United States, physicians must do their part. We must follow our conscience and practice good, basic medicine. We must not be distracted by consideration of profit or intimidated by fear of suit. We must remember our oath of Hippocrates.

Joe Nettles

NEW MEMBERS

Bashiruddin, Ifath G., Internal Medicine — Muscogee — (Active) A50/500-18th St., Columbus 31901

Bellin, Anne, Obstetrics/ Gynecology — MAA — (Active N1) 3193 Howell Mill Rd., N.W., Ste. 306, Atlanta 30327.

Castellano, Penny A. Z., Obstetrics/Gynecology —Cobb — (Active N2) 3570 Clementine Court, Marietta 30066.

Cerilli, Lisa A. — MAA — (Student) 215 Tuxworth Cir., Decatur 30033

Charania, Shelena F. — MAA — (Student) 1520 Farnell Court, Apt. 421, Decatur 30033

Cleveland, Lynwood P., Urology — Newton-Rockdale — (Active) 4139 Hospital Dr., Covington 30209

Coleman, John R., Jr. — MAA — (Student) 763-9 Houston Mill Rd., N.E., Atlanta 30329

Cook, William T., Obstetrics/ Gynecology — MAA — (Active N2) 105 Collier Rd., Ste. 1080, Atlanta 30309

Corbin, Shaun C. — MAA — (Student) 3437 Valley Brook Pl., Decatur 30033

Daumit, Gail L. — MAA — 414 Tuxworth Cir., Decatur 30033

Davis, H. Alisa — MAA — (Student) P.O. Box 21017, Emory University, Atlanta 30322

Davis, James W., Jr., Plastic & Reconstructive Surgery — MAA — (Active N2) 993-D Johnson Ferry Rd., N.E., Ste. 470, Atlanta 30342

Douglass, Thomas G., Internal Med., Chemical Dependency — Cobb — (Active N2) Ridgeview Institute, 4105 South Cobb Dr., Ste. 5, Smyrna 30082

Dowdell, William T., Pulmonary/ Critical Care — Cobb — (Active N2) 54 Tower Rd., Marietta 30060-6947

Drake, Lisa R. — MAA — (Student) 414 Tuxworth Cir., Decatur 30033

DuBiner, Harvey B., Ophthalmology — MAA — (Active) 20 Linden Ave., Atlanta 30365

Dunlap, Robert M., Family Practice — Gwinnet-Forsyth — (Retired) 3100 Club Dr., N.W., Apt 220 Lawrenceville 30244

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Feinberg, Bruce A., Medical Oncology — DeKalb — (Active) 1459 Montreal Rd., Ste. 510, Tucker 30084

Fernadez, Louis R. — MAA — (Student) 1506 Tuxworth Cir., Decatur 30033

Fineman, Mitchell S. — MAA — (Student) 1315 McConnell Dr. #B-414, Decatur 30033

Flick, Arthur B., Orthopaedic Surgery — Stephens-Rabun — (Active) Germany Rd., Clayton 30525

Fraga, Enrique Z., Cardiothoracic Surgery — MAA — (Active N2) 506 Westbridge Dr., Fairburn 30213

Goldberg, Howard C., Urology — Gwinnett-Forsyth — (Active) 100 Medical Center Blvd., Ste. 286, Lawrenceville 30245

Graham, James L., Jr., Family Practice — Tift — (Active N2) 1610 John Orr Dr., Tifton 31794

Greenburg, Joan P. — MAA — (Student) 2408 Summit Pointe Way, Atlanta 30329

Grieme, Bryan R., Diagnostic Radiology — Thomas Area — (Active N1) 113 West Hansell St., Thomasville 31792

Gudger, Garland K., Orthopaedics — Muscogee — (Active) Hughston Orthopaedic Clinic, P.O. Box 9517, Columbus 31995

Hobbie, Karen L. — MAA — (Student) 223 Woodview Dr., Decatur 30033

Hott, Brenda J. — MAA — (Student) 1642 North Pelham Rd., Atlanta 30324

Huddleston, John F., Obstetrics/ Gynecology — MAA — (Active) 25 Prescott St., N.E., Atlanta 30308

Hurd, Thomas E., Anesthesiology/ Critical — Care — (Active) 364 Battle Woods Trail, Marietta 30064

Hutchens, Wayne G., Anesthesiology — Gwinett-Forsyth — (Active N2) Snellville Anesthesia Services, P.O. Box 525, Snellville 30278

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Laird, David M. — MAA — (Student) 3083 Cedar Creek Pkwy., Decatur 30033

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Lyons, Jo M., Neurology — Cobb — (Active) 140 Vann St., Ste. 330, Marietta 30062

Mason, Michael J. — MAA — (Student) 109 Calibre Pl., Decatur 30033

McDonald, Timothy J. — MAA — (Student) 1821 Haygood Dr., Atlanta 30307

Oriol, Jocelyn — MAA — (Student) 1137 Druid Oaks, Atlanta 30329

Phillips, Melanie C. — MAA — (Student) 317 Kings Hill Court, Lawrenceville 30245

Pitts, Robert B., Otolarynology/ Head & Neck Surgery — Carroll/Haralson — 802 Dixie St., Carrollton 30117

Prohaska, M. Gregory, Family Practice — Ware — (Active) 501 West Oneida, Waycross 31501

Ruo, Konny S. — MAA — (Student) 223 Woodview Dr., Decatur 30030

Schachtel, Alison — MAA — (Student) 11305 Brixworth Pl., Atlanta 30319

Schott, Katherine L. — MAA — (Student) 1520 Farnell Crt., #1108, Decatur 30033

Simpkins, Sidney M., Anesthesiology — MAA — (Active) 1850-D Independence Square., Atlanta 30338

Singh, Jitendra P. — MAA — (Student) 1474-C Willow Lake Dr., Atlanta 30029

Smith, Jason L., Dermatology — Floyd-Polk-Chattooga — (Active) 302 West Sixth Street., Rome 30161

Song, Jong-Kyu, Obstetrics/ Gynecology — MAA — (Active) 960 Johnson Ferry Rd., N.E., Ste. 403, Atlanta 30342

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Stahlman, Jon E. — MAA — (Student) Box 21074, Emory University, Atlanta 30322

Steimer, Thomas J. — Gwinnett-Forsyth — (Student) 4618 Armley Point, Norcross 30092

Street, Elizabeth A., Obstetrics/ Gynecology — Cobb — (Active N2) 643 Campbell Hill St., Marietta 30060

Styles, Terry J. — MAA — (Student) 1202 Pine Heights Dr., N.E., Atlanta 30324

Stype, Robert P. — MAA — (Student) 206 Calibre Woods Dr., Atlanta 30329

Thies, David N. — MAA — (Student) 1210-B Church St., Decatur 30030

Ward, Virginia A. — MAA — (Student) 505 Scott Cir., Decatur 30033

Wechsler, Ruben P., Anesthesiology — Cobb — (Active N2) 2550 Windy Hill Rd., Ste. 302, Marietta 30067

Wiess, Kevin L., Emergency Med. — Clayton-Fayette — (Active N2) 6525 Prof. Pl., Ste. C, Riverdale 30274

Weiss, Philip S. — MAA — (Student) 3161 Cedar Creek Pkwy., Decatur 30033

White, Kim R., Internal Med. — Flint — (Active N2) 415-B Fourth Ave. East, Coredele 31015

Windsor, Robert E., Physical Me./ Rehabilitation — Cobb — (Active N2) 535 Tahoma Dr., Dunwoody 30350

Zellner, Deborah H. — MAA — (Student) 1137 Druid Oaks, Atlanta 30329

Zins, Susan A. — MAA — (Student) 7960 Spalding Hills Dr., Dunwoody 30350

PERSONALS

Clayton-Fayette CMS

Paul D. Feldman, M.D., was recently certified as a diplomate of the American Board of Plastic Surgery, Dr. Feldman practices in Riverdale.

Cobb CMS

Robert J. Alpern, M.D., Program Director of Child and Adolescent Psychiatric Services at Ridgeview Institute in Atlanta, has been appointed to the Peer Review Committee of the American Academy of Child and Adolescent Psychiatry (AACAP) for a 3-year term. Dr. Alpern has been active as physician advisor to the Quality Assurance committee of the American Psychiatric Association for the past 7 years. He previously served

Dr. Robert J. Alpern

on the substance abuse committee of the AACAP.

Dr. Robert J. Alpern

Dekalb CMS

Decatur dermatologist, **Robert M. Fine, M.D.,** was recently named 1989 Practitioner of the Year by the Dermatology Foundation.

In addition to his private practice in Decatur, which he started in 1961, Dr. Fine has held a teaching appointment at Emory University School of Medicine, where he is now Clinical Professor of Dermatology. He shares his basic science knowledge as author of the 'The Fine Page,' which appears in the *International Journal of Dermatology.* Through 1989, he has added 112 publications to the literature in peer-review journals.

He is an editor of *Dermatology Times, International Journal of Dermatology,* and a consultant to *Advisor in Dermatology.*

Dr. Fine has been Chairman of the Society for Investigative Dermatology, the American Society of Dermatopathology, and the Southern Medical Association. He is also a member of and has been actively involved in several other professional associations. He has been a member of the board of directors of the American Association of Dermatologists. He has been recognized as a fellow of the AAD, the American College of Allergists, and the American College of Physicians.

Dr. Fine has also contributed as a board member of the Georgia Society of Dermatologic Surgery, of which he is a founder, and also the national Psoriasis Foundation.

Medical Association of Atlanta

Jerome Marchuk, M.D., has received his fellowship into the American College of Surgeons. Dr. Marchuk is associated with Georgia Urology's East Point office.

Hall CMS

Ellis B. Keener, M.D. a neurologist in Gainesville, was elected to the Executive Committee of the Board of Governors of the American College of Surgeons at the Annual Meeting of the College in Atlanta last October.

Whitfield-Murray CMS

Drayton Sanders, M.D., of Dalton is one of 11 new members of the Mercer University Board of Trustees in Macon. He took office Dec. 1, 1989, and will serve a 5-year term ending in 1994.

Dr. Sanders practices pulmonary medicine and is medical department chairman at Hamilton Medical Center and director of respiratory therapy there.

A fellow of the American College of Physicians and the American College of Chest Physicians, Sanders is president-elect of the Georgia Thoracic Society. He is a former president of the American Lung Association.

DEATHS

C. R. Barksdale, Jr., M.D., of Palmetto, a retired family practitioner, died last December of heart failure at his home. He was 76. He had practiced medicine for 9 years in Grantville and for 28 years in Fairburn.

Dr. Barksdale graduated from the University of Georgia and the Medical College of Georgia. During World War II, he rose to captain in the Army Medical Corps in the Philippines.

Retired Thomaston, physician **R. E. Dallas, M.D.,** died last December at the age of 74.

A 1932 graduate of R. E. Lee Institute, Dr. Dallas completed his undergraduate work at the University of Georgia in 1935 and obtained his medical degree in 1939 from Emory University Medical College. He served the U.S. Navy as a commander in World War II from 1941 to 1945 and was an officer on the *USS Gwinn* when it was sunk by enemy forces.

He began his medical practice in Thomaston in 1946 and retired after 40 years in 1985.

Atlanta internist **Charles F. Stone, Jr., M.D.,** died last December of emphysema. He was 78.

Dr. Stone had practiced internal medicine since 1941 with Smith, Stone, and Neely, retiring in 1987.

He graduated from the University of Georgia in 1933 and the Emory University School of

Medicine in 1937. He did postgraduate work at Peter Bent Brigham Hospital of Harvard University and interned at Boston City Hospital and Massachusetts State Cancer Hospital. He was chief resident at Grady Memorial Hospital and a Clinical Assistant professor at Emory.

Dr. Stone was a former president of Atlanta Clinical Society and the Southeastern Clinical Society. He was on the Piedmont Hospital staff from 1941 until his retirement and was a former chief of medicine and former chairman of the board of trustees of the hospital. Dr. Stone was former chairman of the Piedmont Hospital Foundation.

OTHER NEWS

House of Delegates

As a reminder of the democratic operation of your state medical Association, I want to remind *every* MAG member that *you* may voice your opinions and concerns on medicine to the House of Delegates, the Association's policy-making body, at the Annual Meeting to be held April 26-29, 1990, at Callaway Gardens, Pine Mountain.

If you are not an elected delegate representing your component society or Section and wish to present a Resolution to this year's House, you may submit such Resolution by support of either your component society *or any delegate* agreeing to present your item of business.

The deadline for Resolutions is March 29, 1990. Any Resolution which would involve Constitution or Bylaws changes must be received at MAG headquarters on or before March 19, in compliance with the 45-day rule.

All Resolutions received on or before this date will be printed and placed in the Delegates' Handbook, which will be mailed out to all delegates by April 9. Any Resolutions coming in after that date and before April 18 will be printed and distributed during the meeting. Resolutions received after April 18 will be considered late Resolutions and will be forwarded to the Annual Sessions committee for its approval.

We want to urge participation in this House of Delegates by all MAG members. Therefore, please forward any Resolutions your society's or Section's delegates wish to present to the House at your earliest convenience, to: MAG, 938 Peachtree St., Atlanta GA 30309. If you need assistance in composing a Resolution, please contact MAG, 404-76-7535 or 800-282-0224.

Erratum

In MAG's 1989-90 Roster, William J. Hammond, M.D., is incorrectly listed as having two specialties of practice: family practice and general surgery. Dr. Hammond is a family practitioner; the second specialty was included by mistake. We regret this error.

QUOTES

Love affairs have always greatly interested me, but I do not greatly care for them in books or moving pictures. In a love affair I wish to be the hero, with no audience present.

E. W. Howe: *Sinner Sermons, 1926*

While doubt stands still, confidence can erect a skyscraper.

George Lorimer

Be gracious to all men, but choose the best to be your friends.

Isocrates

Fidelity bought with money is overcome by money.

Seneca

Love affairs have always greatly interested me, but I do not greatly care for them in books or moving pictures. In a love affair I wish to be the hero, with no audience present.

E. W. Howe: *Sinner Sermons, 1926*

While doubt stands still, confidence can erect a skyscraper.

George Lorimer

Time is the best medicine.

Ovid: *Remedia amoris, c. 10*

If a man's character is to be abused, say what you will, there's nobody like a relation to do the business.

William Makepeace Thackeray

There are several ways to apportion the family income, all of them unsatisfactory.

Robert Benchley

Take a dose of medicine once, and in all probability you will be obliged to take an additional hundred afterward.

Napoleon I

To Barry E. O'Meara at St. Helena, Sept. 26, 1817

Take a dose of medicine once, and in all probability you will be obliged to take an additional hundred afterward.

Napoleon I

To Barry E. O'Meara at St. Helena, Sept. 26, 1817

MRI UPDATE

Figure 1

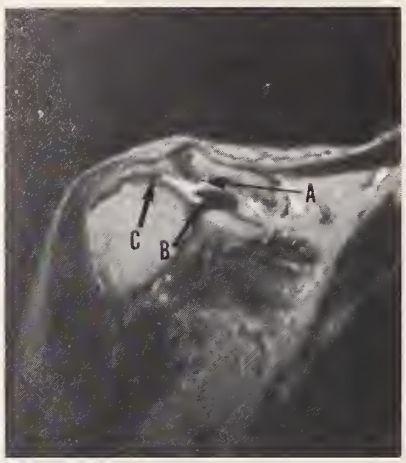

Figure 2

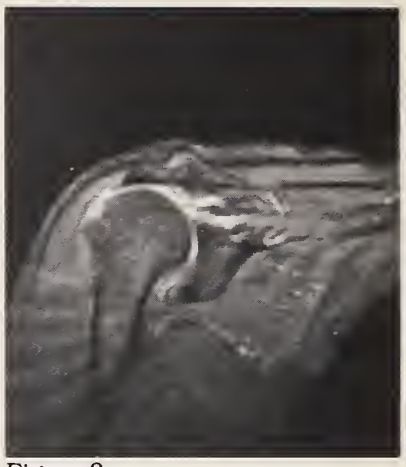
Figure 3

CLINICAL INFORMATION: This is a 69-year-old male who is unable to abduct his right arm and who has difficulty extending his arm. This is associated with right shoulder pain.

FINDINGS: Figure 1 is a proton density image in the coronal plane of the right shoulder. There is degenerative hypertrophy of the right acromioclavicular joint with a prominent inferior projecting osteophyte (A). A roughly linear area of low signal intensity inferior to the right distal clavicle represents the medial aspect of the rotator cuff (labeled B). A thin linear structure of low signal intensity superior to the right humeral head (labeled C) represents the lateral portion of the rotator cuff. Figure 2 is a T2-weighted image again demonstrating the inferior projecting osteophyte from the acromioclavicular joint (A) and the components of the torn rotator cuff (labeled B and C) as previously described. Increased signal intensity material between the torn portions of the rotator cuff represents joint fluid lying both within the joint space and in the subacromial bursa. Image #3 is a partial flip angle image which is sensitive for T2-weighting. This exhibits increased signal intensity in the immediate region of the rotator cuff tear as well as extending lateral over the right humeral head. The level of this slice is slightly anterior to figures 1 and 2 and the increased signal intensity material represents joint fluid extending over the right humeral head into the subdeltoid bursa.

The MR images demonstrate complete disruption of the rotator cuff which may be due to an acute injury or possibly due to chronic entrapment of the rotator cuff by the degenerated right acromioclavicular joint.

COMMENT: MR imaging is the only modality capable of directly visualizing and differentiating the various soft tissue components of the musculoskeletal system. Only CT arthrography approaches this degree of accuracy in the detection of rotator cuff tears, however CT arthrography like its cousin, routine shoulder arthrography, is invasive and requires injection of contrast into the shoulder joint. MR is the imaging modality of choice in the initial evaluation of soft tissue injuries of the shoulder joint with routine or CT arthrography reserved for those patients on whom the MR study was indeterminate.

Atlanta Magnetic Imaging
800 Douglas Road
Atlanta, GA 30342
(404) 256-9296

Atlanta Magnetic Imaging-South
276 Medical Way
Riverdale, GA 30274
(404) 997-9313

Athens Magnetic Imaging, Ltd.
2090-B Prince Avenue
Athens, GA 30606
(404) 353-3873

Augusta Magnetic Imaging
2102 Central Avenue
Augusta, GA 30904
(404) 733-0551

Coastal Magnetic Imaging
Six Wheeler Court
Savannah, GA 31405
(912) 355-5668

Columbus Magnetic Imaging
2131 Comer Avenue
Columbus, GA 31904
(404) 323-7622

Health Images facilities operate their MRI systems with all available upgrades including contiguous thin slices, high resolution head and body coils, state of the art surface coils, and cardiac gating.

Health Images facilities are a community resource available to all area physicians.

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THE MEDICAL ASSOCIATION OF GEORGIA'S 1990 HOUSE OF DELEGATES

CALLAWAY GARDENS INN AND CONFERENCE CENTER PINE MOUNTAIN APRIL 26-28

Next month, the 136th annual meeting of the Medical Association of Georgia House of Delegates, will be held at the Callaway Gardens Inn and Conference Center, near Pine Mountain, Georgia.

The House of Delegates is MAG's legislative body, charged by our Constitution with the responsibility for transacting all business of the Association. Most importantly, the House determines MAG's positions on current issues facing the medical profession in Georgia. And, as always, we will be electing MAG's President-Elect and other officers.

All members of the Medical Association of Georgia are cordially invited to attend the several sessions of our House and, with their elected Delegates and Alternate Delegates, to participate in discussion of the issues under consideration.

Reservations for Lodging

Guest rooms at the Callaway Gardens Inn are available for participants and guests in our House meeting. All MAG delegates and officers have received reservation cards from MAG headquarters. All others must make reservations directly with the Callaway reservation staff, preferably by calling them directly at 800-282-8181. For this meeting, MAG has secured a discounted room rate at the Callaway Gardens Inn of $99 single or double occupancy per night. In addition, lodging is available through Callaway's cottages or villas. Please call the above reservations number for details.

The Auxiliary to the MAG will also hold its 65th Annual Meeting at Callaway, April 27-28. Program information about their meeting follows.

A registration desk will be maintained in the foyer of the Callaway Convention Center, adjoining the Inn, for delegates, alternate delegates, directors, and all members. The registration desk will be open:

Thursday, April 26
4:00 p.m. - 8:00 p.m.
Friday, April 27
7:30 a.m. - 3:00 p.m.
Saturday, April 28
8:30 a.m. - 4:00 p.m.

GENERAL SESSION
Thursday, April 26

The opening General Session will be called to order by MAG President, Joe L. Nettles, M.D., on Thursday, April 26, at 7:00 in the Ballroom.

After opening ceremonies, Dr. Nettles will present MAG Certificates of Appreciation to members who have made special contributions to MAG as well as to other citizens who have distinguished

themselves in service to the medical profession in Georgia. The President will also honor MAG's members who have been in practice for 50 years or longer, those who have been awarded life membership, and those who have died during the past year.

Special events during this opening session will be the address of our annual Guest Speaker and the report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. Grace Walden. Following will be the presentation of MAG's four special awards:

- **Hardman Cup** — presented to an individual for an outstanding discovery in medicine or surgery, or solution of a major problem in public health
- **Distinguished Service Award** — for meritorious service reflecting credit and honor to the Association
- **Civic Endeavor Award** — for outstanding public service and participation in civic activities
- **Family Physician of the Year** — the recipient of this award is determined by the Board of Directors of the Georgia Academy of Family Physicians.

Immediately upon the recess of this session, MAG members, spouses and guest are cordially invited to Callaway's Beach Pavilion for an enjoyable evening of refreshments and entertainment.

FIRST SESSION OF THE HOUSE
Thursday Evening

After these ceremonies, James A. Kaufmann, M.D., Speaker of the House, will convene the House of Delegates at 8:00 p.m. in the Ballroom.

The order of business will include:

- Nomination of candidates for MAG offices, AMA delegates and alternates
- Announcement of Reference Committees for Friday
- Introduction of resolutions or other new business

GaMPAC BREAKFAST
Friday, April 27

MAG's Georgia Medical Political Action Committee (GaMPAC) will sponsor a champagne breakfast on Friday morning, April 27, at 7:30 a.m. in the Ballroom.

REFERENCE COMMITTEES

According to the Bylaws of the Association, all resolutions and reports submitted by MAG officers, members, county specialty societies, or committees which contain recommendations must be referred to a Reference Committee for open hearing.

All MAG members are invited to Callaway Gardens and encouraged to appear and express their views before the Reference Committees. The committees will open their hearings on Friday, April 27, at 9:00 a.m. in the Callaway Conference Center.

Our House customarily features 6 Reference Committees, each with an agenda of somewhat related issues:

- Reference Committee A: Socioeconomics
- Reference Committee B: Medical practice
- Reference Committee C: Legislation
- Reference Committee D: Medical education
- Reference Committee F: MAG's budget
- Reference Committee C&B: Constitution & Bylaws

The April issue of our *MAG Newsletter* will include a list of all issues to be discussed at the upcoming House. We encourage you to become informed on these items and to express your views as to MAG's position regarding them.

SECOND SESSION
Saturday, April 28

The Second Session of the House of Delegates will convene at 9:00 a.m. on Saturday, April 28, in the Ballroom.

Principal items of business will be consideration of reports submitted by the several Reference Committees. The Delegates' vote on each of the numerous resolutions and recommendations brought before the House will help establish MAG's official policies.

Election of officers nominated on Thursday evening will take place during the Saturday morning session. The Tellers will pass out, collect, and count the ballots, and the results will be announced before the lunch break. All newly elected officers will be installed during the evening session on Saturday.

INSTALLATION OF OFFICERS
Saturday Evening

All Delegates, Alternate Delegates, Auxilians, Guests, MAG members and their spouses are cordially invited to the special ceremony for the installation of officers of the Medical Association of Georgia, Saturday evening, April 28, at 6:00 p.m. in the Sweetbay Room of the Convention Center.

At that time, MAG's outgoing President, Dr. Joe Nettles, will address the House and install our new President, William C. Collins, M.D., of Atlanta. Dr. Collins will deliver his inaugural address, and along with other officers of the Association, will take his official oath of office.

PRESIDENT'S RECEPTION

The MAG will honor our outgoing President, Dr. Joe L. Nettles, and Auxiliary President Mrs. Grace W. Walden, at a reception and dance beginning at 7:00 p.m., or immediately following the officers' installation on Saturday evening, in the Balltoom.

Sunday, April 29

In the event that all Reference Committee reports are not acted upon in Saturday's session, the House will be convened at 9:00 a.m., Sunday, in the Ballroom.

SCHEDULE AT A GLANCE. . . .

MAG HOUSE OF DELEGATES
April 26-28, 1990
Callaway Gardens Inn and Convention Center
Pine Mountain

THURSDAY, APRIL 26

4:00-7:00
Registration

7:00-8:00
General Session (Ballroom)
Presiding: Joe L. Nettles, M.D., President
Opening Ceremonies
Report of the President of the Auxiliary to the MAG, Mrs. Grace Walden
Presentation of MAG Awards
Recess

8:00-9:30
House of Delegates, First Session (Ballroom)
Presiding: James A. Kaufmann, M.D., Speaker and Jack A. Raines, M.D., Vice-Speaker
Nominations for Association Officers and AMA Delegates or Alternates
Review of House Agenda
Introduction of New Business
Recess

FRIDAY, APRIL 27

7:30 a.m.
Registration

7:30 a.m.
GaMPAC Breakfast (Ballroom)

9:00-3:00
Reference Committee Hearings

SATURDAY, APRIL 28

8:30 a.m.
Registration

9:00 a.m.
House of Delegates, Second Session (Ballroom)
Report of Reference Committees
Announcement of Election Results

6:00 p.m.
Installation of Officers
Address of the President, Dr. Nettles
Address of the President-Elect, Dr. Collins

7:00 p.m.
President's Reception and Dance (Ballroom)

Auxiliary to the Medical Association of Georgia 65th Annual Meeting

Callaway Gardens, Georgia April 26-28, 1990

CALL TO CONVENTION

Grace W. Walden

"Proud To Be Auxilians"

It is my pleasure to invite each Auxilian across this state to our 65th Annual Convention at lovely Callaway Gardens in the springtime! We will learn of the myriad activities of our county auxiliaries during the past year — gather new ideas for the coming year — and renew friendships as well as making new acquaintances.

Mark your calendars and make your reservations now for this outstanding event.

Grace W. Walden
President, A-MAG

The Auxiliary to the Muscogee County Medical Society and the Bibb County Medical Auxiliary extend an invitation to all Auxilians to attend the State Convention at Callaway Gardens. The Gardens offer something for everyone from active sports to perfect settings for relaxation. Besides golf, tennis, and racquetball, there are 13 miles of roads for jogging or biking. The 2500 acres of lush gardens and lakes provide a perfect place to relax and enjoy nature's beauty. Experience the Sibley Horticultural Center, a 5-acre garden-greenhouse and the new Day Butterfly Center, where one can be a part of the wonder of nature. Join us for a wonderful weekend in April.

Nancy Wolff
Veronica Brooks
Mary Huber
Jan Cowan
Convention Co-Chairmen

Auxiliary Tentative Program

Thursday, April 26

3:00-5:00
Registration and information

7:00
Opening Sessions of the MAG House of Delegates
A-MAG President's Report, Mrs. Charles W. Walden
AMA-ERF Check Presentation

Friday, April 27

9:00-5:00
Registration and information
Hospitality and Exhibits

10:00
Pre Convention Executive Board Meeting
(All former state presidents, state officers, state committee chairmen and members, county presidents and county presidents-elect.)

12:00
Auxiliary Luncheon
(Executive Board, Delegates, MAG Committee on Auxiliary and guests)

Greetings from A-AMA — Mrs. Priscilla Gerber (S. Bruce)

2:00
Opening Session of the Annual A-MAG House of Delegates
Call to Order
Spotlighting County Presidents
Opening Ceremonies
President's Greetings
Introductions
Greetings from MAG President — Joe L. Nettles, MD

Business Meeting
Introduction of Pages
Credentials Report
Convention Standing Rules
Adoption of Program
Minutes
Officers and Committee Reports
Unfinished Business
New Business
Bylaws & Handbook Revisions
Announcements
Recess of Meeting

Exhibition Walk
County Exhibits, Scrapbooks, Doctors' Day, Medical Heritage (Research & Romance of Medicine)

Saturday, April 28

9:00-12:00
Registration
Hospitality and Exhibits

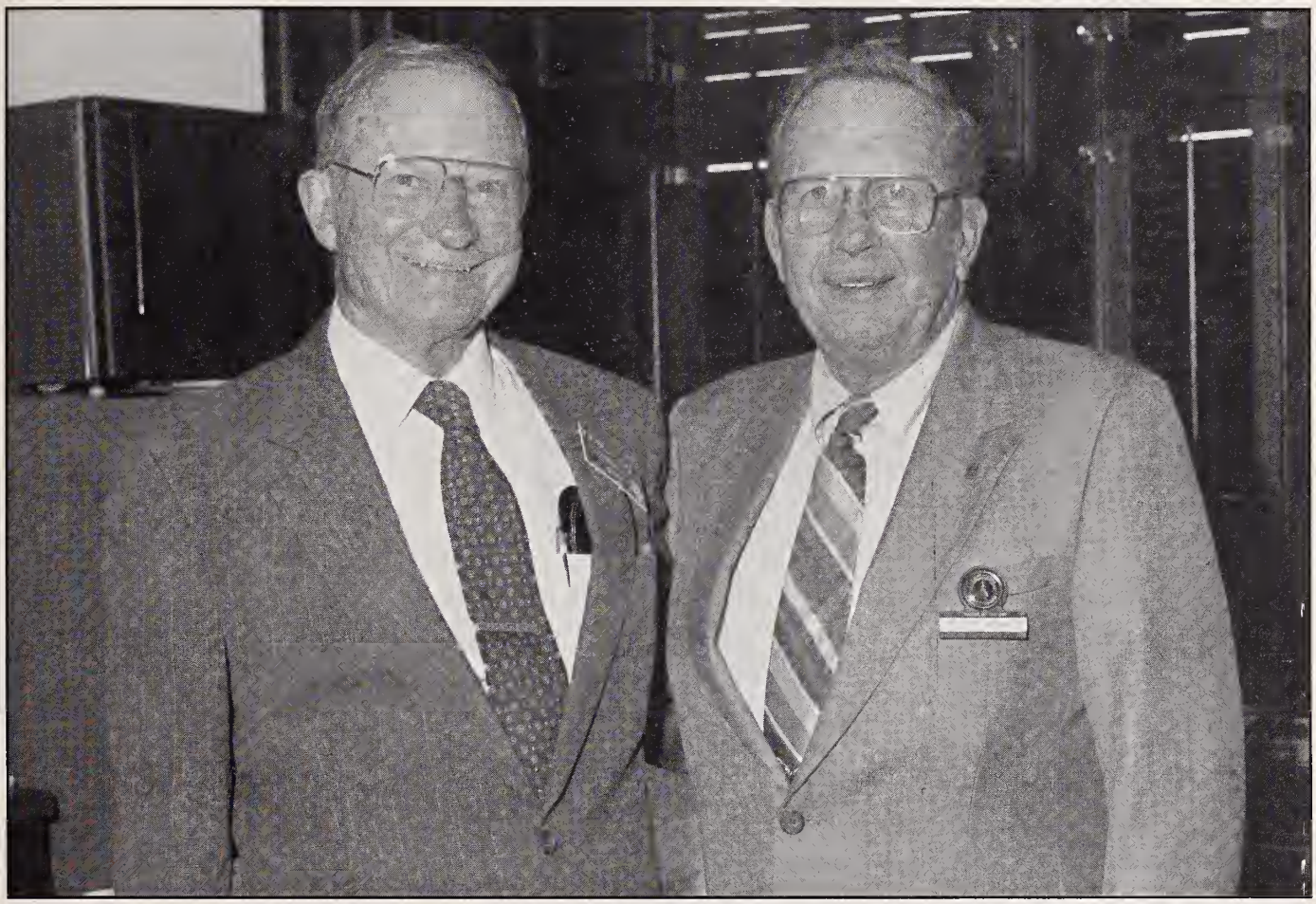
9:00
Second General Session House of Delegates
Introduction of Past State Presidents
Message from Southern Medical Association Auxiliary, Mrs. A. J. Campbell (Janet), President, SMA-A
Memorial Service
Business Continued
  Revised Credential Report
  Election of 1990-91 Nominating Committee
  Election of 1990 A-MAG Delegates to A-AMA Convention
Report of Awards
  Achievement, AMA-ERF, Brawner Certificates of Excellence, Doctors' Day, Membership, Safety, Scrapbooks
Report of 1989-90 Nominating Committee
Election and Installation of Officers
Presentation of 1990-91 President's Pin and Gavel
Inaugural Address — Mrs. Robert S. Hill
Presentation of Past President's Pin
Announcements, Adjournment

12:30
1990 Executive Board Luncheon and Meeting

6:00
Installation of 1990 MAG President
7:00-10:30
Reception honoring Joe L. Nettles, M.D. and Mrs. Charles W. Walden

"Doctor of the Day"

program gives physicians an opportunity to interact with legislators



Senator W.W. (Bill) Fincher (left), a democrat from Georgia's Congressional District 54, was one of several legislators who made a special effort to visit with "Doctor of the Day" Garland E. (Gene) Kinard, M.D., a family practitioner from Rossville during the 1990 Session of the Georgia Legislature in Atlanta. Dr. Kinard had the opportunity to attend committee hearings and observe the House and Senate in Session. Physicians interested in participating in the "Doctor of the Day" program should contact Viki Staley at MAG Headquarters, 404-876-7535 or 800-282-0224. ■

CALENDAR

MARCH

24 — *Augusta:* **Lyme Disease.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

26-30 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-30 — *Atlanta:* **Management Problems of Anesthesia & Life Support in the Cardiac Surgery Patient.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-31 — *Hilton Head Island, SC:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

30-31 — *Atlanta:* **Expert Testimony.** Category 1 credit. Contact Office of CME, Emory Univ. School of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

31-April 1 — *Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

APRIL

2-6 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6 — *Atlanta:* **Sleep Disorders.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-14 — *Pine Mountain:* **Annual Geriatric Symposium.** Category 1 credit. Contact Lamar Cardin, The Medical Center, 710 Center St., Columbus 31994. PH: 404/571-1328.

16-19 — *Atlanta:* **Geriatric Symposium and Board Review.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

18-20 — *Atlanta:* **Nuclear Medicine Update.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19-20 — *Atlanta:* **Neurotrauma Rehabilitation Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19-21 — *Atlanta:* **Nuclear Medicine Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19-21 — *Jekyll Island:* **Vascular Trauma: Diagnosis and Management.** Postgraduate course sponsored by Department of Surgery, University of Florida Health Science Center, Jacksonville, and the Florida Vascular Society. Category 1 credit. Contact Alicia Azouz, UFHSC/J, 580 W. 8th St., Jacksonville, FL 32209. PH: 904/359-6510.

19-22 — *Atlanta:* **American College of Preventive Medicine.** Category 1 credit. Contact A.C.P.M., 1015 15th St., NW, Ste. 403, Washington, DC 20005. PH: 202/789-0003.

21-22 — *Augusta:* **Pathology Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3697.

21-25 — *Sea Island*: **Sixth Annual Masters in Gyn/Ob.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-26 — *Atlanta:* **Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXIII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-27 — *Atlanta:* **Rehabilitation and Treatment Goals in Gastric Urology and Nephrology.** Contact National Kidney Foundation of Georgia PH: 404/248-1315 or Dr. Nancy G. Kutner PH: 404/727-5561.

26-28 — *Pine Mountain:* **MAG House of Delegates.** Contact Lynn Pearson, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535.

29-May 2 — *Sea Island:* **Georgia Society of Ophthalmology.** Category 1 credit. Contact Ray Williams, GSO, Peachtree St., Atlanta 30309. PH: 404/876-7535.

30-May 5 — *Augusta:* **25th Annual Primary Care and Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

The *Journal* Revisited:

Why America Has Dug the Panama Canal

(With Panama so much in the news these days, we thought this reprint from a 1912 issue of the Journal of the MAG *might be of interest to our readers. Then, the threat to health was yellow fever; today, of course, it's drugs. Different times, different problems, yet similar opportunities to expand our knowledge and conscious awareness.)*

WHY has America succeeded in building the Panama Canal, where France failed? Was it because we had more money, better men or better tools? No it was because the French died so fast that they could not make any progress. The French, with an average force of 10,000 employees, lost from death during their construction period 22,000 men. We, with an average force of 33,000 men during about the same length of time, have lost from death 4,000. The French, with an average of 1,600 white employees, lost during their construction period from yellow fever 2,000 men. We, with an average of 5,000 white employees during the same length of time, have lost from yellow fever only eighteen. The important question, however, is the health of the American employees. During the year 1911 we had 10,489 American whites connected with the commission. Their death-rate from diseases was 4.48 per thousand. Of these 10,489 Americans, 6,025 were men and 4,464 women and children. The death-rate from disease among the men was 2.82 per thousand. That among the women and children from the same cause was 6.72 per thousand. These facts are taken from a recent address, at Johns Hopkins University by Col. Wm. Gorgas, Chief Sanitary Officer of the Isthmian Canal Commission. His address appears in a recent issue of the *Journal of the American Medical Association.* Speaking of the condition of the Americans now in the Canal Zone, Col. Gorgas says: "I think a still better way of satisfying one-self with regard to health conditions is direct observation of the American employees. They as a class are rugged and healthy-looking, of good color, and energetic and active in movement. They look more like the farmer and his family of the northwest than like people who have lived in the tropics for four or five years."

Hospitals a Major Contributor to Georgia's Economy, Study Shows

A study just released by the Georgia Hospital Association credits hospitals with being a major contributor to Georgia's economy.

"The Impact of the Hospital Industry on Georgia's Economy," prepared by analysts from both the University of Georgia and Georgia Institute of Technology, shows that every hospital dollar spent generates more than $2.50 in Georgia's communities. That amount includes 82 cents in wages in other Georgia industries, $1.82 in additional revenues to those industries, and eight cents to the coffers of state and local governments.

GHA's president Joseph Parker explains that the study underlines the positive impact Georgians experience from hospital revenues, including Medicaid dollars.

Study findings reveal that Georgia's hospitals provide jobs to more than 100,000 persons, with annual compensation amounting to $2.4 billion. In 1987, the year for which the most recent figures are available, wages and benefits represented 54% of hospitals' total expenses, which came to $4.3 billion. The study also points out that because hospitals are labor-intensive, a large portion of their revenue "returns again and again through the local industries."

The hospital industry's impact on the state's economy is calculated at $7.9 billion, which represents the sum of direct earnings plus the indirect benefits Georgia sees through increased revenues to households, local governments, and to business. Specifically, Georgia's households receive $1.5 billion a year, city and county governments see an additional $71 million, and the state collects $69 million in taxes as a result of hospital operations. Businesses that see the largest benefits are the finance, insurance, real estate industries followed by utilities, personal and business services, wholesale trade, and retail trade. Hospital revenues for the study period totaled more than $4.7 billion, with $1.8 billion coming from federal sources and $2.9 billion from in-state sources.

Authors of the study are Dr. Charles Floyd of the University of Georgia's College of Business Administration and Dr. William A. Schaffer of Georgia Tech's College of Management. The study will be published in the *Georgia Business and Economic Conditions*, a publication of the University of Georgia's College of Business Administration.

Former Grady Director Honored at GHA Convention

J. William Pinkston, who recently retired as executive director of Atlanta's Grady Memorial Hospital, has received the Georgia Hospital Association's Distinguished Service Award for his contributions to health care in Georgia.

GHA presented the award to Pinkston at its annual convention in Atlanta.

Pinkston, who retired November 1, began work with Grady in 1948 as an accountant. In 1955, he became associate superintendent of the hospital, and in 1964, was named superintendent, with the title later changing to executive director.

During his more than 40 years at the hospital, Grady grew to a work force of nearly 4,500 staff members and 700 volunteers. Close to 600 residents rotate throughout the hospital under the Emory and Morehouse Schools of Medicine, and almost 25% of Georgia's physicians have trained there.

Under Pinkston's direction, Grady opened its nephrology center, drug dependency unit, diabetes day care center, pediatric emergency clinic, child care center, observation unit, burn center, poison control center, rape crisis center, high risk nursery and neonatal transport system, sickle cell clinic, and AIDS clinic.

Hospital Association Names New Leaders

Charles H. Keaton, administrator of Hughston Sports Medicine Hospital in Columbus, is the new chairman of the Georgia Hospital Association. The new chairman-elect is James G. Peak, administrator of Jeff Davis Hospital in Hazlehurst.

The new trustees were installed into office during the association's annual convention held last month in Atlanta.

Urban/Rural Hospital Payment Differential May Close Sooner Than Expected

The Prospective Payments Assessment Commission has recommended ending the differential between urban and rural hospital Medicare payments 2 years earlier than Congress plans to do so.

But raising payments to rural hospitals will not call for extra government funds; instead, it will require Medicare to reduce its payments to urban hospitals.

The reasoning behind the recommendation is that Medicare cost-report data now clearly show that rural hospital's Medicare per-care payments have fallen behind those hospital's per-case costs since prospective payment began in 1983.

March in January: Of Reflections and Crystal Balls

"To each one of you the practice of medicine will be very much as you make it — to one a worry, a care, a perpetual annoyance; to another, a daily joy and a life of as much happiness and usefulness as can well fall to the lot of man. In the student spirit you can best fulfill the high mission of our noble calling — in his humility, *conscious of weakness, while seeking strength; in his* confidence, *knowing the power, while recognizing the limitations of his art; in his* pride *in the glorious heritage from which the greatest gifts to man have been derived; and in his sure and certain hope that the future holds for us richer blessings than the past."*

SIR WILLIAM OSLER, M.D.

"No person for any considerable period can wear one face to himself, and another to the multitude without finally getting bewildered as to which may be true."

NATHANIEL HAWTHORNE

"Men are qualified for civil liberty in exact proportion to their disposition to put moral chains upon their own appetites. Society cannot exist unless a controlling power upon will and appetite be placed somewhere, and the less of it there is within, the more there must be without. It is ordained in the eternal constitution of things that men of intemperate minds cannot be free. Their passions forge their fetters."

EDMUND BURKE *(1791)*

"Beyond this place of wrath and tears
Looms but the horror of the shade,
And yet the menace of the years
Finds, and shall find me, unafraid.
It matters not how strait the gait,
How charged with punishments the scroll,
I am the master of my fate;
I am the captain of my soul."

"Invictus"
WILLIAM ERNEST HENLEY

NINETEEN HUNDRED and ninety in our town has opened her doors to a clear and bright new year. It's Monday morning, January 1, 1990. A new year. A new decade. The countdown to the year 2000 begins. This Editor's reflections to appear 2 months distant must be recorded now. A danger there, you see. Reflections, opinions, predictions must stand at least the test of limited time. Expressed in January, at the gateway to the year, they must at best bear some validity in March. It is much as Carl Moyer, our Chairman of Surgery at Barnes Hospital those many years ago, told us of the practice of surgery. "She is a stern mistress," he said. "She gives the test first and the lesson afterwards." Nonetheless, the temptation to look to the future, into the year ahead, on this particular day engulfs one. What indeed lies ahead as we rest on this holiday and gird ourselves for the year ahead? Let one person's thoughts wander among several ponderables.

Of Reimbursement: It has occupied so much of our wakened hours these past years, the matter of monetary return for our labor. We seem to have wandered with such relentless abandon from a position where our efforts were rewarded as means provided, a bartering environment, through monetary rewards seen as individual responsibility to this place where we find ourselves reimbursed through devious channels and by mechanisms beyond precise control. There shall be in this year ahead no lessening of the reins that guide and control those payment mechanisms. Our future mandates an accommodation to a reimbursement system driven by forces other than the individual physician putting value on service rendered and unimpeded in that value setting by considerations of the body social and the body of politics. Will our earning potential be determined by factors other than our desire to work hard and be good doctors? Without much doubt it will be.

Of Regulation: They seem so far away now, those days when I consulted with myself, with my fellow physicians, made a decision, and acted upon it. Now I consult by telephone with a voice in Omaha, or Newark, and receive my instructions. My diagnosis is suspect via a second

opinion. My therapeutic options and decisions are confined and constricted by protocol. Will there be more? Shall the shackles of conformity tighten about my suffering intellect? Yes, indeed I must expect such. I must learn those rules, those regulations, for they will be my partner this year. I must live with them. Beyond this, however, I must position myself, we physicians must, to have input to those rules and regulations. For too long now we have lent silent assent to those among us who violate those ordinary and reasonable rules of professional competence and monetary return for service rendered. We have in place, indeed we developed them ourselves, mechanisms for controlling unacceptable behavior among our peers. This year we must continue that effort. We must not only continue that effort but rather in concert with others formulate those rules and regulations with which we must reside in our future years.

Of Organization and Specialization: We seem so disorganized at times. To speak with so many disparate voices. And yet we are labeled as the most powerful lobby group. The most influential pressure group. Our umbrella national organization musters less than a majority of our profession among its membership. And as to specialization, there seems no end to the dismantling of the "compleat doctor" of years past as the mad rush of technologic innovations creates an environment where it is untenable to think of a single person capable of encompassing the wealth of knowledge necessary to effectively manage the range of afflictions impacting the human organism. The bounds of a single specialty will of necessity grow evermore confining. And so it will be that "organized medicine" will be seen to organize and function in a political sense evermore strongly along specialty lines. Therein lies the danger of the center of medicine's political influence and power fragmenting into uncoordinated uselessness. This year must see an effort to muster the physicians of this country, those involved and those uninvolved in the organizational aspect of medicine, into a coherent body committed to a cooperative effort designed to mold our health care system into one whose primary aim is the care of the sick and whose rewards to those who provide that care is sufficient to attract the best of our society.

'Our future mandates an accommodation to a reimbursement system driven by forces other than the individual physician putting value on service rendered . . . .'

Of Prestige: What became of it, we ask ourselves? What became of those heady days when simply to be known as a physician carried with it an unanticipated acceptance into the ranks of society of those considered at face value to be worthy, trustworthy, honorable, altruistic? Much of that acceptance has dissipated perhaps as the change in reimbursement led us into a world where fiscal reward found us to look more to monetary gain from service rendered than to the evermore satisfying reward of that sense of having performed well and rendered needed care to the suffering. It has become a malignancy eating away at the foundation of our integrity, this focusing of so many of us upon the material gain provided by the practice of medicine, overlooking those more subtle yet more satisfying rewards. This year ahead must foremost find us, even if in some small way, attacking the fixation on monetary return for effort that has so insidiously become a part of us.

Of our future: What do they hold for me, those years I may be granted in which to practice medicine? For my physician son who has far more of those years alloted to him than do I? Will the ability of others to exert influence on my manner of conducting my professional life become evermore pervasive? Perhaps, and I must learn to live with that intrusion, for it has some value, and I must accept, difficult though it be, the fact that the past failure of my generation to regulate ourselves has created a void, indeed a necessity, that other concerned parties must understandably fill. Must I learn to accept, hopefully with some equanimity, the onrush of "universal health care," — dread as it sounds, of socialized medicine? In some form, by whatever acronym it be called, I must make friends with it, for the restructuring of our system of caring for the infirm in our society is now a Juggernaut that defies

defeat. Will my life in medicine in the years ahead be the happy, challenging, fulfilling, and rewarding ones of years past? I see no way around it. I shall insist upon it!

I have an architect friend above whose drawing table is a sign which reads, "I'd rather you steal my money than steal my time." I might modify that for the benefit of the others who will be a part of my professional life in the future. I might say to them, "You may steal my money and regulate my life, but you cannot steal my happiness nor my satisfaction from what I do."

"For too long now we have lent silent assent to those among us who violate those ordinary and reasonable rules of professional competence and monetary return for service rendered."

Should I say to our youngest child now applying to the medical schools of our state for entrance to the class of 1990, "You must not do this, you will not be happy, the practice of medicine is not what it used to be?" Certainly I shall not! I shall say to him, as did Roland Hanlon, M.D., one time President of the American College of Surgeons speaking a short time ago to a group of surgeons at a gathering in Montreux, Switzerland, a small town on the edge of Lake Geneva surrounded with majestic mountains covered with snow, "The times, the system, the reimbursement mechanisms will change but I am confident, I have no doubt, that just as these majestic mountains have stood and shall continue to stand for so many years, so shall a thousand years from now surgeons still be found to be practicing surgery with their hands, their heads, and their hearts." That's what I shall say to him, to that son who wants to become a doctor. I have a deep conviction that unfortunate though it be, sickness and injury and infirmity will continue to reside amongst us. I believe that society shall always need us. I see no higher calling than answering that summons. I envision no greater happiness nor any more challenging task. Perhaps he was right, "The only thing we have to fear is fear itself."

"This year must see an effort to muster the physicians of this country . . . into a coherent body committed to a cooperative effort designed to mold our health care system. . . ."

CRU

QUOTES

The man of greatness never loses his child's heart.

MENCIUS
Discourses, IV, c. 300 B.C.

Oh, that my tounge were in the thunder's mouth!
Then with a passion would I shake the world.

SHAKESPEARE:
King John III, c. 1596

We went to Mannheim and attended a shivaree — otherwise an opera — the one called "Lohengrin." The banging and slamming and booming and crashing were something beyond belief.

S. C. CLEMENS (MARK TWAIN):
A Tramp Abroad, IX, 1879

One pain is lessen'd by another's anguish;
One desperate grief cures with another's languish.

SHAKESPEARE:
Romeo and Juliet, I, c. 1596

If all men defined "honorable" and "wise" alike there would be no debate on earth. As it is, each man defines these words for himself, and only the names remain unchanged.

EURIPUDES:
The Phoenissæ, c. 410 B.C.

The first advice of a woman is always the best.

FRENCH PROVERB

In vain the sage, with retrospective eye,
Would from th' apparent what conclude the why,
Infer the motive from the deed, and show
That what we chanced was what we meant to do.

ALEXANDER POPE
Moral Essays, I (Of the Knowledge and Characters of Men), 1733

Personal Thoughts on Laparoscopic General Surgery

Arlie R. Mansberger, Jr., M.D.

The laparoscopic surgical techniques described in the article by Drs. McKernan and Saye on p. 157 of this issue obviously are new to most surgeons, regardless of expertise and technical proficiency. Change is inevitable, progress is not.

‘The authors are to be commended for their efforts to find alternate and perhaps better ways of performing abdominal procedures.’

The authors are to be commended for their efforts to find alternate and perhaps better ways of performing abdominal procedures on a subset of patients who not only will not require "open" intervention in the future but also may be treated as outpatients. It is equally obvious that if successful, costs will be decreased. These are worthy goals.

However, the authors have a responsibility to the profession to report *all* aspects of the process and document same (to include pathology, complications (which will occur), definitive indications and contraindications, etc.

For example, the pathology of the resected specimens has not been cited. The pathology in each instance must have been minimal in order to allow the type of laparoscopic dissection described. I personally cannot envision laparoscopic cholecystectomy being accomplished in the kinds of patients who are referred to our center for cholecystectomy. Many of them, as you know, are exceedingly difficult to do through standard incisions.

I am concerned about positive identification of the cystic artery. There is, of course, the potential of ligating the right hepatic artery in a significant number of patients where the right hepatic artery courses in close proximity to the gallbladder.

I am also concerned with respect to adequate dissection of the cystic duct and appropriate ligation of that duct in an adjacent position to the common duct, thus eliminating the long cystic duct stump which can be a source of stone formation and can lead to the post-cholecystectomy syndrome.

‘These developments and their evaluation should be confined to a few centers where appropriate training precedes implementation.’

What are the peer review and quality assurance mechanisms in their outpatient settings?

In my opinion, these developments and their evaluation should be confined to a few centers where appropriate training precedes implementation (addressed by the authors).

Those centers, in turn, have the responsibility of reporting *all* aspects of their accumulative experience and evaluating the results of that experience in detail sufficient to allow scientific evaluation by peer groups. Only then can the "progress" of the changes be evaluated. ■

Dr. Mansberger is Professor and Chairman, Department of Surgery, School of Medicine, Medical College of Georgia, Augusta, GA 30912. Send reprint requests to him.

Commentary on Laparoscopic Cholecystectomy

John Page Wilson, M.D.

"Where will this procedure fit into the armamentarium of the surgeon? How will it be introduced to the profession and public?"

The article on laparoscopic cholecystectomy by Drs. McKernan and Saye on p. 157 of this issue prompts considerations that go far beyond the matter of techniques on how to take out the gallbladder.

Laparoscopy is a proven medium. It has become an essential element in the armamentarium of the gynecologist. It is long overdue in the hands of the general surgeon, who is coming to appreciate its potential and practicality. In the private teaching hospital with which I am associated, laparoscopy, as well as endoscopy, is being incorporated into the curriculum of the residents in general surgery.

Laparoscopic cholecystectomy may become a practical option in the management of gallbladder disease. Like many other recent treatments for gallbladder disease, it also may have limitations in its usage.

The questions of concern are two: One, where will this procedure fit into the armamentarium of the surgeon? Two, how will it be introduced to the profession and public?

The first question will probably be answered only by clinical usage, but the application must be done and evaluated in comparison to comparable cases managed by traditional methods (the simple, uncomplicated cholecystectomy, which would be the most likely candidate for laparoscopic removal, can be performed in most patients with a minimal incision of less than two inches, hospitalization of less than 48 hours, and a mortality rate of less than 0.1 percent — a gold standard which will be difficult to exceed).

The real concern, then, is whether the publicity associated with this introduction may mislead both the public and the profession to insist on its widespread use before an adequate evaluation has been made of its effectiveness and risk in the clinical setting in which it will generally be used.

This second question is much more difficult to evaluate. It is apparent that this procedure will not be introduced in the optimal fashion, i.e., controlled, perspective application with objective evaluation.

It is much more likely that it will become the mechanism by which surgeons will rush to be the first or only physician (or surgical center) to do the procedure. If this is, indeed, a desirable procedure with widespread application, it is incumbent that training and education in its technique be made available.

That there will always be progress in medicine, and particular surgery, is a desirable given. It is also a given that the major problem is in sorting out the desirable from the undesirable. Few procedures can be adequately evaluated at their initial introduction. One does not have to remember too far back to recall gastric freezing, internal mammary artery ligation for angina, and a number of other promising, attractive alternatives which didn't quite pan out.

The authors have certainly done a service to the profession in serving notice that the procedure is now with us and in sharing their experience with us. Time and (we hope cautious) experience will resolve these questions. ■

Dr. Wilson practices general surgery. Send reprint request to him at 100 Tenth St., NW, Atlanta, GA 30309.

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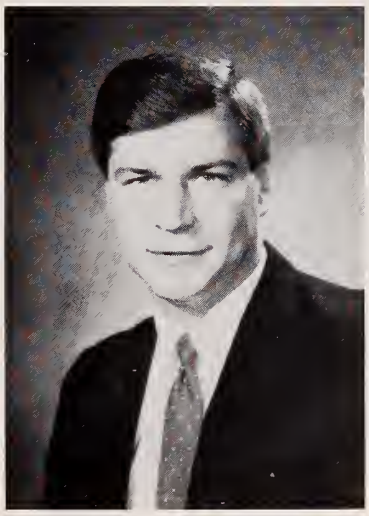

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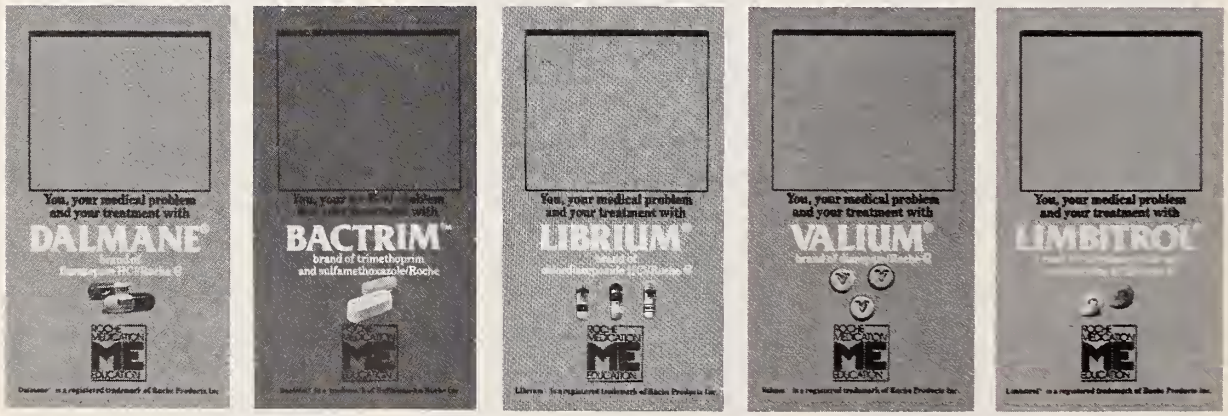

ROCHE ME MEDICATION EDUCATION

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The Epidemiology of End-Stage Renal Disease in Georgia

William McClellan, M.D., M.P.H., Donna Brogan, Ph.D.

Abstract

WE HAVE EXAMINED the incidence of end-stage renal disease (ESRD) in Georgia in 1986 and 1987. We found high age-sex-race specific and total incidence rates compared to rates reported for other U.S. populations. Cause-specific and total ESRD incidence rates were significantly higher among blacks as compared to whites. In both races, the majority of new cases of ESRD occurring in Georgia during 1986 and 1987 can be attributed to diabetes or hypertension. Total ESRD rates were not uniform throughout the state; counties of the Coastal Plain (South) were significantly more likely to have higher rates than counties in the Piedmont Region (North). These patterns of ESRD in Georgia have implications for possible prevention efforts.

THE DEVELOPMENT and availability of effective treatment for terminal renal failure has resulted in an increasing population of patients treated for End-State Renal Disease (ESRD) in Georgia. This report describes the incidence, prevalence, and regional distribution of ESRD in the state in 1986 and 1987. We have found that the incidence of ESRD in Georgia is higher than previously reported for other populations and that a substantial proportion of the overall occurrence can be attributed to causes that are potentially preventable. Furthermore, there are regional variations in the incidence of ESRD which may have importance for health planning and prevention efforts.

Methods

End-Stage Renal Disease Network 20 was an association of all Medicare dialysis facilities in South Carolina, Georgia, and Russell County, Alabama, excluding Catoosa, Walker, and Dade counties in Georgia. It operated under the provisions of Public Law 95-292 and was responsible for surveillance of ESRD care. The network routinely collected information about new patients, including age, sex, race, primary cause of renal failure, and county of residence at the time of beginning dialysis and also transfer. The initial treatment, subsequent changes in therapeutic modality, transfer to other facilities, and survival status of patients were routinely ascertained. Information for new ESRD patients who entered the Network 20 System in a Georgia dialysis facility during 1986 and 1987 was used for this study.

State population estimates for 1987 by age-sex-race categories were obtained from the Georgia Office of Planning and Budget. An average annual rate was calculated by dividing the total number of cases from 1986 and 1987 by twice the population estimate

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TABLE 1 — Annual Age-Sex-Race Specific ESRD Incidence Rates Per Million Population, Georgia, January, 1986, through December, 1987

	White			*Black*		
Age	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
0-9	6.1	6.4	6.3	14.0	2.8	8.5
10-19	8.9	14.4	11.5	22.5	14.4	18.5
20-29	37.4	30.4	34.0	99.6	72.0	85.3
30-39	50.6	43.0	46.9	263.1	157.5	206.0
40-49	100.0	60.2	80.0	574.7	430.6	495.8
50-59	198.6	144.1	170.5	1076.8	1059.1	1066.8
60-69	371.4	227.0	291.3	1377.6	1607.3	1515.7
70-79	453.6	240.0	321.6	1382.0	1540.0	1481.9
80+	356.5	135.4	196.3	1208.0	673.5	833.9
TOTAL	98.6	75.0	86.6	300.9	334.4	318.6

SOURCE: ANNUAL REPORTS OF ESRD NETWORK 20 1986 AND 1987

TABLE 2 — Cause-specific ESRD Annual Incidence Rates/Million Population, by Race, Georgia, 1986-1987

Cause	*White*	*Black*	*RR*
Hypertension	21.5	130.8	6.1
Glomerulonephritis	7.2	14.5	2.0
Diabetes mellitus	26.2	98.5	3.8
Polycystic kidney disease	3.0	3.0	1.0
Hereditary interstitial nephritis	1.1	1.9	1.7
Analgesic abuse nephritis	2.7	5.5	2.0
Interstitial nephritis	6.2	14.0	2.3
Obstructive uropathy	.7	2.5	3.7
Multiple myeloma	1.0	3.3	3.3
Unknown	6.0	19.7	3.3
Other	11.3	26.3	2.3
TOTAL	86.9	320.0	3.7

SOURCE: ANNUAL REPORTS OF ESRD NETWORK 20 1986 AND 1987

and is expressed per million. Since only new patients treated initially by dialysis are included in the case definition, individuals with ESRD who are transplanted without first being dialyzed are not counted. This will tend to underestimate the actual incidence of ESRD, although any effect will be negligible since the total number of such cases is small.

Cause-specific rates of ESRD were calculated directly from the primary cause of renal failure reported by the dialysis facilities for each new patient. No independent confirmation of the stated cause of renal failure was made.

County-specific rates were calculated by using the 1987 county population estimates. After visually inspecting the distribution of county-specific rates, the state was divided into two regions for analysis of geographic differences in the incidence of ESRD. Counties below a line drawn from Muscogee County in the Southwest and Richmond County in the Northeast, and including Marion, Taylor, Crawford, Bibb, Twiggs, Wilkinson, Washington, Glascock, and Jefferson, were termed Coastal Plains or Southern Region counties. Those above the line, excluding counties defining the line, were termed Piedmont or Northern Region counties. This line defines two physiographically distinct regions in Georgia which are substantially different demographically and economically.[1]

Results

Average 1986 and 1987 age-sex-race specific annual incidence rates for ESRD in Georgia are shown in Table 1. Rates rise with age through the 8th decade for whites and for black males and through the 7th decade of life for black females, and then decline for all sex-race groups. Blacks are at greater risk than whites at all ages, with relative risks varying between 1.4 and 6.3 for different age strata. The greatest black:white relative risk is seen between ages 40 and 60 years. Within races, the male:female relative risks vary between .6 and 2.6 for whites, overall 1.3, and between .9 and 4.9 for blacks, overall .9.

The racial distribution of new cases of ESRD in 1986 and 1987 was white males, 22.3%; white females, 17.6%; black males, 26.7%; and black females, 33.4%. This contrasts with a state racial distribution of white males of 35.2%; white females, 37.2%; black males, 14.8%; and black females 12.8%.

Cause-specific incidence rates by race are shown in Table 2. Hypertension nephrosclerosis and diabetic renal disease were the most frequently reported causes of ESRD in both races. Blacks had higher incidences for both diseases. The black:white relative risk hypertensive nephrosclerosis was 6.1 and for diabetic renal disease, 3.8. Among other reported causes of ESRD, glomerulonephritis of all kinds was the third most frequent cause of ESRD in both races. Analgesic abuse was the fourth leading cause for blacks and fifth for whites, while polycystic kidney disease was the fourth leading cause among whites and fifth among blacks. With the exception of polycystic kidney disease, blacks were at greater risk then whites for each

cause of ESRD, with black:white relative risks varying between 1.7 and 6.1 (Table 2).

Hypertensive nephrosclerosis was reported as the cause for 24.7% of all white cases of ESRD and 40.9% of all black cases in 1986 and 1987, while diabetes accounted for 30.2% of white and 30.8% of black cases. These two causes alone contributed 64.9% of all cases of ESRD in Georgia during 1986 and 1987.

Crude incidence rates of ESRD for ESRD Network 20 (GA & SC) have risen steadily from 66 per million for whites and 275 per million for blacks in 1983 to 90 million for whites and 402 per million for blacks in 1987. Whites have an annual rate of increase of 6.0 cases/million/year and blacks 32.0 cases/million/year. The race-specific annual crude incidence rates and black:white relative risks are shown in Table 3. Blacks were 3.96 to 4.47 times more likely than whites to develop ESRD during this time interval; there was no dramatic change in black:white relatives risks over time.

Regional differences in ESRD rates were found when county-specific rates within Georgia were computed. ESRD rates for 1986 and 1987 tended to be higher in the Coastal Plain Region.[1] Sixteen counties reported no cases of ESRD during 1986 and 1987; 7 (43.7%) were in the Piedmont Region, and 9 (56.3%) were in the Coastal Plain. These were sparsely populated counties, average population 6381 (Range 2100-14748). All of the counties with crude ESRD rates above 400 per million and 8 of 9 (89%) counties with rates between 300 and 400 per million were located in the Coastal Plain region. The overall distribution of rates shows that counties in the Coastal Plain were more likely to have higher rates than those in the Piedmont (Table 4).

Discussion

The 1986 and 1987 incidence rate of ESRD in Georgia is high compared to rates previously reported for other U.S. populations. Mausner, et al found rates of 56/million for white males, 32/million for white females, 202/million for black males, and 177/million for black females in the Greater Delaware Valley Region in the 1970s.[2] These rates are typical of rates reported during the 1970s for the Southeastern United States, Birmingham, Alabama, and San Francisco, California.[3,4] The race-sex-specific incidence rates per million reported by Eggers for the total U.S. between 1978 and 1980 were white males, 74; white females, 52; black males, 186; and black females, 154.[5] National ESRD incidence rates for a later time period indicate rates of 85, 89, and 97 for whites and 252, 260, and 281 for blacks for 1983, 1984, and 1985, respectively.[6] The 1986-87 Georgia ESRD rates of 98.7 and 75.3 for white males and females, respectively, or 86.8 for whites, are similar to the 1985 Na-

TABLE 3 — ESRD Annual Incidence Rates, by Year and Race, Georgia and South Carolina (Network 20), Rate/Million Population

Race	*1983*	*1984*	*1985*	*1986*	*1987*
White	66	72	81	88	90
Black	275	317	313	350	402
Black:White Relative Risk	4.17	4.40	3.86	3.98	4.47

SOURCE: ANNUAL REPORTS OF ESRD NETWORK 20 1987

TABLE 4 — Distribution of Counties, By Annual ESRD Incidence Rate and By Geographic Region, Georgia, 1986 and 1987

	Geographic Region		
Annual Incidence Race	*North Number (%)*	*South Number (%)*	*Total Number (%)*
0-96	19 (27.1)	18 (20.9)	37 (23.7)
97-146	27 (38.6)	13 (15.1)	40 (25.6)
147-202	16 (22.9)	24 (27.9)	40 (25.6)
203-681	8 (11.4)	31 (36.0)	39 (25.0)
TOTAL	70	86	156

$X^2 = 18.65$, 3DF, $p < .001$

SOURCE: DATA ON FILE ESRD NETWORK 6. RATES FOR WALKER, DADE, AND CATOOSA COUNTIES, ALL IN THE PIEDMONT (NORTH) ARE NOT INCLUDED.

tional ESRD incidence of 97 for whites. However, the 1986-87 Georgia ESRD incidence for blacks of 319.1 is higher than the National ESRD incidence of 281 for blacks. Race-specific incidence rates per million reported for a population in South Central Los Angeles in 1985 were 361 for blacks and 64 for whites, compared to a black rate in Georgia in 1986 and 1987 of 319.1 and a white rate of 86.8.[7]

Although the 1986-87 incidence of ESRD in Georgia is higher than other reported rates, the age-race-sex patterns seen are consistent with earlier reports. A characteristic feature is the increase in incidence rates with age in all race/sex groups. Further, the excess in male risk seen in black and white has been reported by three groups.[2, 8, 9]

Hypertension and diabetes accounted for 65% of all new dialysis patients in Georgia during 1986 and 1987.

The excess black risk for all cause ESRD found in the present study was first recognized by Easterling, who reported a relative risk of blacks of 3.8 in 1977.[8] The black:white relative risk for all cause ESRD incidence in Georgia of 3.7 is comparable to that reported by Easterling and Mausner, et al (2.5-3.2): Rostand, et al (4.3); Hiatt, et al (3.2); Eggers (2.7); Weller, et al (4.3); and Ferguson, et al 2.9.[2-5, 7, 10] The peak in black:white relative risk seen between ages 40 and 60 in our population is later than that reported by Rostand, et al between ages 30-39, and of smaller magnitude, 6.5 versus 9.0.[4] Eggers reports a peak black relative risk of 4 occurring during the 6th decade of life.[5]

Information for new ESRD patients who entered the Network 20 System in a Georgia dialysis facility during 1986 and 1987 was used for this study.

The high ESRD incidence rates in Georgia may reflect a number of factors. ESRD incidence is an indirect measure of the rate of terminal renal failure occurring in a population. The ESRD rate reflects the underlying occurrence of renal failure in the population, selection criteria used to initiate treatment for renal failure, the availability of treatment, and the access to treatment for those selected to receive therapy. Changes in any of these factors can potentially influence the observed ESRD rate.

The geographical differences in the occurrence of ESRD are of some interest in this respect. The counties on the Coastal Plain have a higher county average black population (34.2% versus 19.4%), than those in the Piedmont. Since black ESRD rates in Georgia exceed those of whites, the difference in the proportion of blacks in the population of counties on the Coastal Plain may explain some of this increased incidence. However, these same counties tend to have slightly lower per capita physician rates (67 per 100,000 versus 70 per 100,000) which may reflect a decreased access to health and dialysis care.[11] Further study of these possibilities is in progress.

An important feature of the epidemiology of ESRD in Georgia relates to potential prevention efforts. Hypertension and diabetes accounted for 65% of all new dialysis patients in Georgia during 1986 and 1987. Patients with hypertension or diabetes, particularly the elderly and black, should be periodically screened for evidence of renal damage. If impaired renal function is identified, prompt efforts to increase blood pressure control are warranted.[12, 13] Although less clear, diabetics may also benefit from improved blood sugar control as well.

In conclusion, we have found incidence rates for ESRD in Georgia during 1986 and 1987 higher than previously reported, particularly among blacks, the elderly, and people residing on the Coastal Plain of Georgia. Both the overall ESRD incidence rate and cause-specific rates for hypertensive nephrosclerosis an diabetic ESRD are higher than previously reported for other populations. A substantial proportion of the new cases of ESRD in Georgia (68%) is attributed to hypertension and diabetes.

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Laparoscopic General Surgery

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Operative laparoscopy as an extension of diagnostic laparoscopy offers a whole new armanentarium to the field of surgery. . . . This article reports the authors' experience with laparoscopic cholecystectomies and appendectomies.

(EDITOR'S NOTE: The advancement of the art and science of medicine requires an ever changing armanentarium of both our cognitive functions as well as our technical equipment and our manipulative capability. It must be so, or else we would find ourselves yet drawing blood with leeches and replacing it with goose quills. That advancement and perfection of our professional service to the sick must, however, follow the well worn path of reasonable conception, thoughtful design of studies, and meticulous monitoring and reporting of the successes and failures of our endeavors. The following paper represents one of the first reports in the domestic or foreign medical literature of a new approach to the management of the diseased gallbladder. Your Editorial Board has reviewed it carefully, recommended and received improvement in the writing, and now prints it well aware of its limitations. You will find elsewhere in this issue of your Journal *commentaries by two highly respected surgeons in our state concerning the matter. Read the article and the observations of these physicians with careful attention, for we see here a major shift in the care of the surgical patients.)* *CRU*

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Introduction

THE USE OF the laparoscope as a diagnostic tool for pelvic and abdominal pain has received increased interest over the past few years.[1, 2, 4, 6-8] Operative laparoscopy in gynecology has been well established with the event of fiber lasers and newer laparoscopic instrumentation. More recently, operative laparoscopy in general surgery has emerged. The first laparoscopic cholecystectomy using fiber lasers was performed on June 22, 1988, by McKernan and Saye. The first series of laparoscopic cholecystectomies was reported by Reddick, et al. in 1989.[3] The earliest studies of laparoscopic appendectomies with detailed operative techniques were reported by Semm in 1983.[5] Other reports of laparoscopic appendectomies have followed in the German literature.[9] This article reports our experience with laparoscopic cholecystectomies and appendectomies.

Methods and Materials

In this series, 12 patients underwent appendectomy, and eight underwent cholecystectomy. All patients in the cholecystectomy group had symptoms of cholecystitis and had cholelithiasis confirmed by nonfunctioning OCG or ultrasound. Patients ranged in age from 32 to 52 years. The first two cholecystectomy patients were admitted to the hospital for observation.

Those undergoing appendectomy ranged in age from 16-50 years. Six of the 12 patients had acute appendicitis. The other six had endometriosis with chronic pelvic pain. In these latter cases, the appendix was removed to prevent future diagnostic problems often encountered in patients with endometriosis and recurring right lower quadrant pain.

Ultrasonography was performed on both groups of patients, with special emphasis on common duct. All patients had normal common ducts with no evidence of choledocholithiasis. Our current protocol dictates that if the common duct is enlarged or if evidence of choledocholithiasis exists prior to surgery, the patient should undergo ERCP, sphincterotomy, and removal of common duct stones. (There have been none to date.)

Patients with temperatures above 101 degrees, jaundice, coagulopathies, or other medical conditions that would need in-hospital observation were not included in this study.

Technique

The patient should be placed in the dorsal lithotomy position for pelvic or right lower quadrant pain and in the supine position for cholecystectomy. Insert the Hasson® 11mm trocar through a periumbilical incision. Utilizing a WISAP® insufflator, insufflate the peritoneal cavity with carbon dioxide (CO_2) to an intraperitoneal pressure of 12mm of mercury (Hg). Next, insert the Wolf® 10mm laparoscope through the periumbilical trocar. Following diagnostic laparoscopy, trocars should be placed for the surgical procedure.

For cholecystectomy, place two 5mm trocars in the subcostal margin of the right upper quadrant (RUQ) under direct visualization. Make one 11mm puncture wound to the right of the midline halfway between the xyphoid process and the umbilicus. Place a third 5mm trocar 2 inches to the right of the umbilicus.

We believe that surgeons should complete approximately 1 year of basic course work in diagnostic laparoscopy before preceptoring and performing laparoscopic operative procedures.

Using a 5mm probe, elevate the liver for visualization and surgical access. Suction irrigation cannulae should be placed through the punctures in the RUQ. Retract the gallbladder inferiorly with grasping forceps. With scissors inserted through the left cannula, dissection at the level of the cystic artery and the infundibulum of the gallbladder. Then isolate the cystic duct from adjacent structures and sever it, making sure to leave an adequate stump attached to the common bile duct. Place a zero chromic endoloop around the cystic duct, and tie it at the junction of the cystic duct and gallbladder. Clean the cystic duct stump to its junction with the common duct. If dissection of the cystic duct-common duct junction is difficult, operative cholangiogram can be used not only to detect stones in the common duct but also to appreciate the length and course of the cystic duct, thus, eliminating a long cystic duct stump. Place a chromic endoloop at the junction of the cystic duct and the common duct. The cystic artery should then be identified, severed, and tied with two zero chromic endoloops.

In dissection of the cystic artery, great care should be taken, not only to identify the cystic artery but also to dissect it down to its origin from the hepatic artery or dissect it distally to its juncture with the gallbladder. In this manner, anomalies such as the cystic artery arising from the right hepatic artery can be identified, thus preventing ligation of the right hepatic artery. After copious irrigation, inspection will confirm the appropriate positioning of the endoloops and effective hemostasis.

Attention is then turned to the gallbladder itself. Using either a KTP® or Argon® laser, remove the gallbladder from its bed. Irrigate the abdomen with copious amounts of saline solution, and inspect all areas for hemostasis. Insert 5mm panaview scope through one of the 5mm trocars. Remove the 10mm scope from the umbilicus. Insert grasping forceps through the umbilical trocar, grasp the gallbladder, and remove it enbloc under direct visualization utilizing the 5mm scope. Wash the abdomen again with copious amounts of saline solution. Finally, remove all trocars in the usual fashion after removal of carbon dioxide.

With regard to the appendix, the entire small bowel should be visualized prior to appendectomy. Under direct visualization, make three 5mm puncture wounds — one in the suprapubic area, one in the left lower quadrant, and one in the right lower quadrant. All punctures should be made below the bikini line. Next, place a zero chromic suture on a Keith® needle at the base

of the mesentery at the junction of the appendix and the cecum. The suture should be tied extracorporeally to secure the mesoappendix which is then severed with Argon® or KTP® laser, thus freeing the appendix from its blood supply. Place two endoloops on the base of the appendix adjacent to the cecum, and place a third tie in a position that would allow transection of the appendix, thus leaving two ties on the cecal side of the appendix. The Argon® laser set at 13 watts should be used to transect the appendix. After transecting the appendix, use the laser to coagulate and sterilize the inner aspects of the appendiceal lumen both on the appendiceal stump and on the appendix. Insert 5mm panaview scope through one of the 5mm trocars. Remove the 10mm scope from the umbilicus. Insert grasping forceps through the umbilical trocar, grasp the appendix, and remove it enbloc under direct visualization utilizing the 5mm panaview scope. Wash the abdomen with copious amounts of saline solution. Then remove all trocars in the usual fashion after removal of carbon dioxide.

Discussion

Laparoscopic apendectomy and cholecystectomy are viable alternatives to traditional surgical modalities. These procedures eliminate traditional incisions and significantly decrease the amount of postoperative pain. Benefits include outpatient treatment and earlier resumption of normal activities (typically 7 days). Certainly, not all patients with appendicitis or cholecystitis and cholelithiasis are candidated for these procedures.

Diagnostic laparoscopy is essential to evaluate potential candidates. Patients should receive complete preoperative information, with special emphasis on the possibility of conversion to an open rather than a purely laparoscopic procedure. (There have been none to date in our experience.) In performing endoscopic surgery, it is essential that instruments be set up and immediately available if bleeding, abnormal anatomy, or any unforseen complications develop necessitating immediate open surgery.

These procedures, as all operative procedures, are not without risks. Proficiency in the use of the laparoscope, fiber laser, and all accessory instruments is essential to prevent complications inherent to the laparoscope. We believe that surgeons should complete approximately 1 year of basic course work in diagnostic laparoscopy before preceptoring and performing laparoscopic operative procedures. Our center currently requires that surgeons wishing to perform laparoscopic procedures meet the following criteria:

1. Completion of a basic course in general laparoscopy.
2. Performance of 25-50 diagnostic laparoscopies under direct supervison in a preceptoral setting.
3. Completion of a course in operative laparoscopy which utilizes specific operative techniques, instrumentation, and use of fiber lasers.
4. Completion of a course in each separate operative technique, being preceptored in that technique for at least five of each procedure.

The average time presently for an appendectomy is 45 minutes and for the gallbladders is about 1 ½ hours. We are currently evaluating the use of clips in the place of our chromic endoloops for both ligation of the cystic artery and of the cystic duct. We are also developing and beginning to implement new instrumentation that is more applicable to general surgery versus gynecologic surgery.

Operative laparoscopy as an extension of diagnostic laparoscopy offers a whole new armamentarium to the field of surgery. It is also being expanded to patients with intestinal obstruction and extensive abdominal adhesions. Further communications will be forthcoming.

Results

All patients in both groups experienced uneventful recoveries. They all experienced some shoulder pain which is commonly to any laparoscopic procedure. There were no complaints, however, of any symptoms or abnormalities that differed from those usually associated with diagnostic laparoscopy for gynecologic procedures. All patients received a prophylactic dose of second generation cephalosporin.

In the cholecystectomy group, the pathologic diagnoses confirmed the presence of cholelithiasis in all patients, with six having a microscopic diagnosis of chronic cholecystitis and two with severe, chronic cholecystitis. For the two patients admitted to the hospital, laboratory studies and vital signs obtained the morning after surgery were normal. The patients were discharged on oral analgesics and a regular diet.

The first two appendectomy patients admitted to the hospital were also discharged the following morning on oral analgesics and a regular diet.

The cholecystectomy patients had home health care nurses provided for the first 16 hours postoperatively. The appendectomy patients did not need this service. Patients in both groups returned to work within 2 weeks; 92% did so within 1 week.

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An Economic Analysis of the Economic Burden of Cigarette Smoking in Georgia

Dwight R. Lee, Ph.D.

Introduction

IN A RECENT ARTICLE in this *Journal*, Wassilak, Smith, McKinley, and Sikes (WSMS) estimated "The Health and Economic Burden of Cigarette Smoking in Georgia in 1985."[1] According to the WSMS estimate, based on their assessment of the medical costs and the lost earnings resulting from a variety of diseases and accidents associated with smoking, the total cost of smoking in Georgia during 1985 came to over $1.5 billion. Most of the analysis in their article is based on medical studies which the author of this comment lacks the training to evaluate. However, estimates on the cost of smoking, such as the one by WSMS can be, and often are, used as the economic basis for public policy. While WSMS make no policy recommendations on smoking, they do accept a crucial assumption behind most such recommendations when they state that "there are indeed costs due to tobacco use borne by others."[1] Therefore, it is appropriate for an economist to evaluate this claim made by WSMS (and widely accepted by others) that cigarette smoking imposes social costs over and above the private costs paid by the smoker. In order to proceed on the basis of economic analysis, I accept WSMS's health-related estimates as published as the basis for my analysis.

One study which empirically examined the connection between smoking and worker absenteeism found, when one controls for type of work, that there is no connection.

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Let me point out at the onset, however, that as far as public policy toward smoking is concerned, the total cost of smoking is, by itself, without significance. People engage in many activities that are costly in terms of both direct monetary expense and physical risk but which are not the object of public policy concerns. As long as the cost of a legal activity is paid for by those who engage in it, there is no economic basis for government involvement in the choices that individuals make regarding that activity. So the important question is not how much smoking costs in Georgia, or anywhere else for that matter, but how much of that cost is paid for by smokers. While it is believed by some that smokers impose much of the cost of smoking on nonsmokers, in fact there is no sound basis for this belief. Straightforward economic analysis indicates that most, if not all, of the cost of smoking is paid for by smokers. Furthermore, the empirical work that has been done on the question, shows that once existing taxes on cigarettes are taken into account, smokers are more than paying their own way.

Lost Wages Due to Smoking

Well over half of the costs claimed by WSMS to be associated with smoking in Georgia are the result of smokers missing work due to illness and premature death. Although it is not clear from their article whether WSMS overstated the connection between smoking and missed work, this is commonly done in studies such as theirs for reasons to be explained. Also, the cost of missing work, regardless of the cause, is directly imposed on the absent worker in the form of lower earning and is not in any meaningful sense imposed on "society at large," to use the words of WSMS.[1]

There have been many studies that have argued that smoking imposes a social cost in terms of lost productivity because smokers miss more work than do nonsmokers. Assuming that it is in fact true that smokers, in general, have a greater absentee rate from work than nonsmokers, this by itself tells us nothing about the connection between smoking and worker absenteeism. Smokers are more likely than nonsmokers to be employed in blue collar jobs which require greater physical effort and are performed in riskier work environments than white collar jobs. Not surprisingly, blue collar workers, whether they smoke or not, have higher absentee rates than white collar workers.

Neither should anyone be surprised by the fact that pipe and cigar smokers, who are predominantly employed in highly paid professions, miss less work than do nonsmokers. Not many would conclude that pipe and cigar smoking increases the smoker's productivity. And neither is it reasonable to conclude that smokers in general are less productive because they smoke. Indeed, one study which empirically examined the connection between smoking and worker absenteeism found, when one controls for the type work, that there is no connection.[2]

Even if there were a connection between smoking and worker absenteeism, however, this would have no more public policy significance than would a connection between deer hunting and worker absenteeism. People enjoy engaging in a larger number of activities that cause them to miss work occasionally or to work fewer hours than they could. But missing work imposes a cost on the worker in terms of diminished chances for promotions and lower salary and wages. This is a private cost, not a cost to society in general. Individuals are the rightful owners of their time, not society. Therefore, there is no more economic rationale for government to be concerned if people work fewer hours because they choose to smoke than if they work fewer hours because they choose to take a part time job in order to pursue a hobby.

If an activity is connected with missed work by virtue of the fact that engaging in it increases the likelihood of premature death, the private cost people associate with that activity is obviously greater than the value of foregone earning. So any costs resulting from foregone earning due to engaging in risky activities are more than taken into consideration by those engaging in them. People are free to take the risks associated with such activities as skiing, scuba diving, hang gliding, hunting, using chain saws, climbing ladders, suntanning, and overeating, and the fact that they do so indicates that the benefits they derive from risking injury and premature death are greater to them than the costs. As long as people are reasonably informed about the risks of an activity, the presumption is that they are in the best position to decide for themselves how much risk to take; unless, of course, much of the cost of taking those risks are imposed on others. When costs are imposed on others, as they are in the case of speeding, for example, then government does step in, with justification, to regulate the risky activity. But the case for government regulation of speeding is not that speeders will reduce their earning by injuring or killing themselves. This may be a high cost, but it is a cost that the speeder is strongly motivated to take into consideration.

As long as the cost of a legal activity is paid for by those who engage in it, there is no economic basis for government involvement in the choices that individuals make regarding that activity.

The Social Cost of Health Care

Many will respond to the above discussion by arguing: Sure, if people had to pay the full cost of their health care, then society would have no business meddling in their decisions to engage in activities that imposed risks primarily on them. But since much health care costs are paid for through government programs and group health coverage, those who risk injury and ill health are shifting much of the cost of their risky behavior to others. Doesn't this provide a justification for government to tax smokers in order to discourage them from smoking and to make them pay the full cost of their medical care if they continue smoking? This is a good question. But the answer is not nearly as obvious as most people assume.

The first point that can be made is that if we can justify taxing one activity on the grounds that those who engage in it are risking their health, then we can justify taxing a large number of risky activities on

the same grounds. Why not impose special taxes on motorcyclists, skydivers, and compulsive overeaters, for example, in order to make them pay for the full costs of their health care?

But for the purpose of argument, let's assume that for some reason which the critics of smoking have yet to make clear, the purported risks of smoking are more of a concern in terms of publicly financed medical costs than are the risks associated with other activities. Under this assumption, one may conclude on the basis of the medical costs estimates of WSMS that cigarettes should carry a special tax to pay for the health care costs which smokers impose on others. But how large should the tax be? If this question is analysed properly, it has to be acknowledged that if smokers are damaging their health and reducing their life expectancy, then they are also subsidizing nonsmokers by paying more into Social Security and private pension funds than they will receive in retirement.

A careful attempt was made in a recent article in the *Journal of the American Medical Association* to determine the net costs that smokers are imposing on others when the "retirement subsidy" smokers provide is taken into consideration.[3] Assuming that the medical costs smokers are estimated to impose on others are imposed immediately, and applying an annual discount rate of 5% on the future retirement subsidy from smokers, the *JAMA* study concluded that the net cost that smokers impose on others is equal to $0.15 per pack. This compares to an excise tax on Georgia smokers of $0.28 per pack ($0.12 state tax and $0.16 federal tax). So smokers are not only paying their own way in Georgia (and in all other states as well), but may in fact be subsidizing nonsmokers. And this conclusion follows even when special significant is attached to the view that smokers may receive a significant medical subsidy from nonsmokers. But is there any justification for attaching special significance to such a medical subsidy, even if it exists?

If it makes sense to tax smokers differentially to make them pay for subsidies they receive through publicly financed health care, then why doesn't it also make sense to except smokers from paying taxes to support programs in which they subsidize others?

If government programs which finance health care were the only ones which transferred wealth from one group to another, then focusing attention on any medical subsidy that smokers may receive from such programs might be understandable. But there are a large number of government programs which either intentionally or unintentionally transfer wealth from one group to another, and there is no obvious reason for concentrating on medical programs while ignoring the rest. Even if smokers are "winners" with publicly financed health care, most smokers are "losers" with agricultural price support programs, import restrictions, welfare programs, trucking regulation, western water projects, and a host of other government programs. There is no evidence that smokers would be net "winners" in this transfer game even if there were no excise taxes on cigarettes. If it makes sense to tax smokers differentially to make them pay for subsidies they receive through publicly financed health care, then why doesn't it also make sense to exempt smokers from paying taxes to support programs in which they subsidize others?

Despite a widespread belief that the cigarette excise tax should be increased because smokers impose costs on nonsmokers through their demands on medical care, there is no evidence that smokers are failing to pay their own way. Even if it is accepted that smoking is a health hazard, and that smokers make greater use of medical care than nonsmokers, careful analysis suggests that any cost smokers are imposing on nonsmokers is more than made up by existing excise taxes on cigarettes. There is simply no reasoned basis for concluding that cigarette taxes should be increased further in order to cover any subsidy they may be receiving through publicly funded health care programs.

Passive Smoking and Smoking Related Fires

In addition to the costs resulting from the smoker's ill health, WSMS also estimate health costs resulting from so called "passive smoking" and smoking-related fires. Again, for the sake of argument, the WSMS estimates will be accepted, although empirical attempts to establish a connection — either statistical or causal — between passive smoking and health are very controversial

even within the medical community. According to WSMS estimates, the cost associated with passive smoking in Georgia came to $18,556,031 during 1985. This amounted to $0.024 for each of the 758.7 million packs of cigarettes smoked in Georgia during that year. The WSMS estimate of $67,246,002 for the health cost of smoking-related fires in Georgia during 1985 works out to slightly less than $0.09 per pack smoked in Georgia during that year. So even if we accept these costs as costs smokers impose entirely on others, the policy relevant cost of smoking is increased by less than $0.0115 per pack. When this cost is added to the $0.015 per pack figure estimated in the *JAMA* article,* the total of $0.0265 per pack is still less than the $0.028 per pack Georgia smokers are paying in excise taxes.[3]

* It should be pointed out that this involves some double counting, and therefore exaggerates the estimated costs, since the *JAMA* estimate includes some costs for smoking-related fires.

Conclusion

The purpose of this comment is not to criticize the empirical conclusions of WSMS. The author has neither the professional qualifications nor the personal inclination to make such a criticism. But estimates of the medical costs of smoking, such as those of WSMS, are invariably seized upon as justification for public policies that subject smokers to extra taxation and regulatory control. It is important, therefore, to consider whether such policies are justified in the state of Georgia, by the WSMS estimates. As an economist, the author is able to provide a useful perspective that is too often overlooked in the public policy discussion of smoking.

From the public policy perspective, the important question is not how much medical expense, if any, if associated with smoking. Many activities involve significant risks of increased medical expense. The important question is: Are smokers shifting much of the expense associated with smoking to others? Unless the answer is yes, there is no economic justification for singling smokers out for public policy attention. And when the question: Do smokers pay their own way? has been subjected to careful study, the conclusion is that they do. Indeed, given the existing level of taxation on cigarettes, the evidence is that smokers more than pay their own way in the state of Georgia.

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OB/GYN Across the Pond

Susan Wheatley, M.D.

WHAT AN OPPORTUNITY! As a third-year resident in OB/GYN, a month's elective time! No call. No requirements. Study something I am interested in. That was easy — gynecologic urology. Where? Well, there were plenty of big names in this country, but my cultural horizons needed broadening as much as my educational ones. London. They speak English (although they swear we don't), and several hospitals were doing the lion's share of urodynamics and bladder suspension surgery. Ms. Linda Cardozo of King's College hospital in South London accepted my application, I bought an airline ticket, and that was that.

It's hard to recall now exactly what I expected. I had heard so much about the United Kingdom — its socialized medicine and the people in general. I had heard they didn't like Yanks much. Well, they'll like *me*, of course — won't they?

Not knowing anyone in London (or all of England for that matter), I arranged to stay in the dormitory that adjoins King's. Big mistake. I arrived in the typical downpour, jet lagged and with enough luggage for at least a year, and found King's was 85 years old without the first sign of renovation in that entire time. The key to my room looked as though it would open the gates to Windsor Castle. And the room was dreadful — tiny, peeling plaster, tubs at the end of the hall. Oh, well, it's only for a month.

I hurriedly stashed a few things, hid my traveler's checks and passport, and call Ms. Cardozo's office on Harley Street. Anybody who is *anybody* in English medicine has an office on Harley Street. Those few select patients who can afford private health care are privileged to see their physicians there.

The training system for English physicians is very different and difficult to compare with America's. After high school, one first completes 5 years of medical school, then rotates through 1 or 2 years as a houseman — the clinical equivalent to our rotating internship. At this point, the GP is essentially finished with formal education.

The average specialist (OB/GYN, surgeon, etc.) then completes from 4-8 more years of study in his or her specialty. There are several tracts, including research or a subspecialized field. The juniors are called Residents; research people and upper levels are registrars. All this time they are addressed as Doctor, but upon completion of specialty training, they become Mr. or Ms. They view it as a form of reverse snobbery that they are now so important they no longer need a title of distinction. Beyond that level are the professors. And then comes the royal family, I think.

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Ms. Cardozo's secretary told me she was in "theatre" — no, not a matinee. They never tired of teasing me for saying O.R. (or E.R., which they call Casualty, as though it were a wartime statistic).

Admittedly, the OR was not the only thing I found drastically different. Apart from the ancient facilities in general, the ORs are not in one central area. Rather, the GYN OR is just off the GYN ward. Ortho OR is adjacent to the Ortho ward, etc. And I do mean ward. There are no private rooms or even semi-private rooms. The GYN ward has 35 beds, with the bathroom (W.C. or Loo, excuse me) at the end.

The English system is also one of mass rounds. Each morning, a different attending (called Consultant) makes "early" rounds — 8:30 usually. They find that a dreadfully uncivilized time of day. Rounds consisted of 20-25 people standing at each bedside and, in turn, describing a complete history and physical exam to the crowd assembled. Unfortunately, in order to be heard by 25 people, 4 or 5 of the patient's neighbors also heard the most intimate details of her history. It really didn't seem to bother anyone. I think everything is a matter of expectation. No one in this country would dream of staying 5 days for a routine vaginal delivery without complications anymore. That's what the English expect, and possibly why the National Health Service is broke! One woman was admitted my first day in London for a pre-op workup for her hysterectomy. She had a history of alcoholism and DTs. She had her surgery on day 10 and was still on the ward when I left 1 month later. She was 44, and had no complications.

Thank goodness Ms. Cardozo and her three research registrars, which she lovingly dubbed the "urodynamos," were terrific. "Brilliant," I think they would say. Each is funded for 1-3 years by private pharmaceutical companies to do research and some minimal clinical duties. I did 40-45 urodynamic evaluations while I was there and saw *lots* of pathology.

Other than the socialistic aspect, the most striking difference between our two medical systems revolves around our present legal climate.

While their medicine is free, they still wait years (on the waiting list) to accomplish anything. They are required to enter the system through their GP and be referred, adding even more time before being seen. The waiting list for surgery in some places is 1-2 years. Anybody ready to sign up for the old socialized system yet?

We had journal club that first night, and I made out my schedule. Urodynamics and surgery, mostly with Wednesdays free to sightsee in London. Terrific. Oh, excuse me — "brilliant"! There was even a big party that first weekend to which I was invited. A fortuitous thing. I had spent hours seeking out a hotel I could afford, but at the party met a GP who was between roommates and had a spare room for several weeks. Are you kidding? Her flat was 6 minutes walk through a park to King's. Thank you!

With housing much more agreeable and a native (actually from Wales) to act as tour guide, I saw a great deal of London and the immediate environs. Boy are they into old buildings, architecture and museums! The transportation system is excellent, and I was a pro on the trains in just a few days. I chalked up Kew Gardens, Windsor Castle, Stratford-upon-Avon, Cambridge, Oxford, Greenwich, Hampton Court, and Ipswich all in day excursions from London. It's a beautiful country. I even managed to get to Brighton for a weekend at the beach and to Endinburgh, Scotland, (maybe the highlight of the trip) before returning home.

Probably the most unusual thing that happened occurred my second day in England. Ms. Cardozo was scheduled to give a lecture at the Royal College of Obstetricians and Gynecologists near Regents Park, so I tagged along. She didn't tell me that the audience was District IV (which includes Atlanta) of the ACOG! I knew several people in the room — small world!

Other than the socialistic aspect, the most striking difference between our two medical systems revolves around our present legal climate. Registrars there routinely do vaginal breech deliveries, mid forceps, and boast a section rate less than 10%. They do thousands of IUDs and hormone pellet implantations and much more clinical research than their American counterparts without fear of litigation. There's a lot to envy in their practice.

There were so many adventures I could never begin to describe them here. I saw five shows in 4 weeks and tried to sample as much British cuisine as I could find. (If you value your coronaries, avoid the fish and chips at all cost.) The pubs were really the neatest thing. The food was reasonable and consistently good, as was the atmosphere, conversation, and beer (a little warm, a little strong). Wish they would catch on here.

As usual, time flew, and suddenly I am home — and on call. I have quit craving tea every day around 4:30 and am glad to be back to separate men's and women's changing facilities in the "theatre." We may not be quite as civilized as the English, but I'm glad to be home. I am better for the experience, but I would never change places.

It was a great month, and I would not trade the experience for anything I learned especially, though, how wonderful our medical system is despite its flaws and how much we *don't* need it to be socialized.

State of the Section

Resident Physicians' Involvement in Organized Medicine

Mark S. Litwin, M.D.

THE FIRST ORDER of business will be the consideration of a resolution that neckties be offically banned from this meeting. I'd like to dispense with any debate on this issue and move immediately to a vote. All in favor, please signify by saying, "Aye." . . . the motion carries.

Five years ago, the chairperson of the Resident Physicians Section (RPS) was a man by the name of Clayton Griffin. He stood here in Honolulu and began the 1984 Interim Meeting of the RPS with the same introductory resolution. It passed overwhelmingly then, too.

Clayton Griffin was the first national AMA person with whom I ever had contact. In the spring of '84, during the organization of the Medical Student and Resident Sections in Georgia, Clayton visited us at the statewide meeting in Savannah. He was the RPS chairperson-elect at the time, so his function was primarily to help start the state RPS. But the medical students got him as well. Clayton's remarks to the Sections were inspirational, but it was after the meeting that I came to understand why this man had been elected to lead the AMA-RPS.

I was very concerned with how we would fit in with the national body, but Clayton took issue with that concern. He explained to me that the AMA is a democratic body of enormous resources made up of individuals with equal representation. He told me that our issues *are* the AMA's issues, because it is *our* organization. He told me of how the Resident Section had first turned the attention of the AMA onto the topic of tobacco in the United States. At one time, the AMA had interests in the tobacco industry. Now, of course, the AMA is the most powerful advocate in the anti-smoking lobby, the strongest national supporter for the campaign to produce a smoke-free society by the year 2000.

But this did not happen by itself. A group of hard-working, responsible young men and women sat over a decade ago in a room much like this one and adopted the earliest precursors to the AMAs present strong policy against tobacco. And it all started in with a group of concerned residents in someone's living room, in a house staff lounge, in a conversation during morning work rounds. From that humble beginning grew a fundamental philosophy which the AMA now uses abundant resources to support — that is, the courage of individuals, the power of democracy, the strength of a unified voice.

In order to be kinder and gentler physicians, we must respond with a training environment that encourages sensitivity with our technology and compassion with our triumphs over disease.

That was certainly not the first controversial issue that the RPS had tackled, but it did bring residents into the limelight in this organization. And ever since then,

Dr. Litwin is Chairperson of the Resident Physicians Section of the American Medical Association. This is his speech at the 13th Interim Meeting of the Resident Physicians Section in Honolulu, Hawaii, on December 1, 1989. His address is 33 Pond Ave., #201, Brookline, MA 02146.

we haven't been able to escape it. Keep an eye on the back of this room during our session tomorrow and watch how many older members of the AMA stop by to see what the residents are talking about, what the RPS is debating, what actions we are formulating. They look at us and see unabashed, relatively unscathed truth. They see vision. They see their legacy. They see the practicing physicians of tomorrow who will someday be taking care of them and their children. They smile and know that the future of American medicine is in good hands.

Our voice *is* heard loud and clear in the AMA, not because we yell, but because we articulate our opinions in a manner that is sophisticated, well-researched, well-documented, and well-constructed. We question authority, but first we raise our hand.

The physicians of yesterday treated patients from birth to death. The physicians of today treat patients from womb to tomb. But we are the physicians of tomorrow, and we will treat patients from erection to resurrection.

And nowhere is the strength of our voice more evident than in the last six months on the reform of graduate medical education. We used to call this issue, "Resident work hours," until Brian Greenberg suggested that "GME reform" sounded a lot less self-serving, a lot less like a union gripe, and a lot more like the educational and patient care concerns of a mature group of resident physicians.

As survivors in the draconian, back-breaking, cynicism-breeding system of residency training in the United States, we have attentively watched the unfolding of the most pivotal issue in residency training this century. In January, 1987, a New York grand jury issued a report that indicated the entire process of graduate medical education as we know it. The panel called for sweeping reforms that impugn the very conscience of our teaching institutions in their struggle to provide high quality health care with shrinking dollars.

The sage and solemn masters of our training environment have been challenged in a manner that is unprecedented in American medical history. The American public demanded that residents' 36-hour shifts and 120-hour weeks be placed in the medical archives with ether drop anesthesia and bloodletting.

Keep an eye on the back of this room during our session tomorrow and watch how many older members of the AMA stop by to see what the residents are talking about, what the RPS is debating, what actions we are formulating.

State legislatures and agencies throughout the country have underscored this crusade by proposing new laws and regulations to reform what is perceived to be a serious threat to the high quality of American health care. At least a dozen states have formally addressed this issue, and legislation remains under consideration in many of them.

Our position in the RPS has been that reform will be more steadfast if it arises within the medical community. So we went to work. Two and a half years ago, the RPS assembly sat in a room just like this and debated the nuances of what would soon become our most controversial and publicized issue this decade. We sent our recommendations to the AMA House of Delegates, who referred it to the Council on Medical Education, who studied it and asked the AMA to urge the ACGME to produce a specialty-specific plan to address the problem of resident overwork. Many months and meetings later, the ACGME and its residency review committees finished their process of revising the special requirements for residency accreditation. The *medical* specialties did a pretty good job of enacting significant reform. But virtually everyone who examined the solutions from the *surgical* specialties agreed that their response was grossly inadequate.

In a sanctimonious statement, foreshadowing the general surgery revisions, the American College of Surgeons (ACS) succeeded in inflaming *non*-surgeons with its position that surgical training programs are unique in their need for "continuity of care," a term used by the ACS to distinguish surgical patients from others. The ACS dismissed resident fatigue as a contributor in judgement errors and rebuked the current emphasis on resident work hours. Taking this lead, the Plastic Surgery Committee now requires an average of every other night *off* call, implying that some stints may place residents on in-house call every night. Meanwhile, the Neurosurgery Committee formalized its call on residents to work "without regard to time of day, day of week, number of hours already worked, or on-call schedules." In this environment, it is difficult to understand how the Neurosurgery Committee could simultaneously state that patients have a right to expect healthy, alert, and responsive residents. And in a vapid move, the Thoracic Surgery Committee invoked the "continuity of care" stance in a vaguely worded position that "duty assignments should not cause undue fatigue or sleep deprivation."

When the ACGME approved these banal revisions, we went to work again. In June, the RPS brought a resolution to the AMA House of Delegates that asked for AMA policy

that favored several basic parameters to be applied to residency accreditation. Our resolution asked the AMA to support language in the ACGME's general requirements that would compel all residencies to allow for one 24-hour period in seven free of program duties and for schedules that placed residents on in-house call no more often than every third night, averaged over four weeks. Well, after four intimate months in the democratic process, I am pleased to announce to you that last November (1989), the AMA Board of Trustees adopted a *firm and decisive* policy that calls for both of these as basic minimum standards to be required of all residency training programs. In addition, the AMA trustees urged the ACGME to direct each residency review committee to adopt a specific maximum number of hours per week. The AMA went on record in favor of these reforms.

The AMA realizes that patient well-being and physician well-being are inseparable. In order to be kinder and gentler physicians, we must respond with a training environment that encourages sensitivity with our technology and compassion with our triumphs over disease. This AMA policy began as a grass roots effort by a group of residents, like you and me, who believed in an ideal and worked very hard to transform their goal into a workable solution to a difficult problem.

There are many ways to contribute as a group or individually. In the last 6 months we have seen the inauguration of a brand new weekly column in *JAMA* that is specifically dedicated to resident physicians. A lot of people have worked quite diligently during the past year and a half to bring resident issues regularly onto the pages of JAMA. On September 8, 1989, the "Resident Forum" became a reality. "Resident Forum" appears weekly in JAMA and is written *by* residents *for* residents. We have already featured resident-written articles on subjects as diverse as resident duties during emergency transports, GME reform, communication in medicine, AIDS, and Hurricane Hugo. I encourage each of you to go home next week and write five or six hundred words about a topic you care about and send it to the RPS office for publication in *JAMA*.

Five years ago, Clayton Griffin stood here as RPS chairperson and took off his necktie. And as many of you know, 2 weeks ago, Clayton Griffin died. He was a trauma surgeon at UMDNJ in New Jersey. Clayton died of AIDS.

We resident physicians are about to inherit a medical community in chaos, and we have a responsibility to do everything we can to end the scourge of AIDS. Today's residents are the physicians of the 21st century, and *AIDS is our disease*. It is killing our generation, our peers, our friends. We must rally against the greatest challenge that we will face in our professional lives. Just as polio and yellow fever were conquered in generations before us, we must set *this* goal above all others. We must conquer AIDS.

In many ways, Clayton's life was a metaphor for how he chaired the Resident Section. Clayton understood much more than just the AMA bylaws and the Sturgis guide. He knew that with robust leadership and heartfelt conviction, the residents of the AMA and of this nation could make a difference. And he made sure that the issues of importance 5 years ago were brought to the forefront of this Association's attention. Today, it is our responsibility to continue to be the conscience of the AMA and of American medicine. We must realize that today the future of medicine is in jeopardy. And we must rally to guarantee that we will be able to provide high quality health care for a population of aging baby boomers and for all our patients.

We are not the lost generation. We are not the generation of social rest. Our generation is actively confronting its future and helping to steer the course of our destiny. We have energy and power and dreams.

As survivors in the draconian, back-breaking, cynicism-breeding system of residency training in the United States, we have attentively watched the unfolding of the most pivotal issue in residency training this century.

We have made great strides since we met 6 months go in Chicago and since we met 5 years ago here in Hawaii and since we met 10 years ago. And with each new year, we face new challenges. Much of what we have accomplished was reflected in the visionary mind of Clayton Griffin.

But Clayton is not dead. For every resolution we debate, every action we adopt, every policy we seek draws its strength from the small group of residents who thought it up, wrote it down, and brought it here to this assembly. Each one of us in this room cares about the environment of medicine in which we train and practice. Each one of us has a vision. And we come together to spend hours arguing intensely over issues (and semicolons) and then go forth with a united voice to carry our concerns to the body politic of American medicine.

To quote the late Robert F. Kennedy, "It is from numberless diverse acts of courage and belief that our history is shaped. Each time a person stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, it sends a tiny ripple of hope, and crossing each other from a million different centers of energy and daring, these ripples build a current which can sweep down the mightiest walls of oppression and resistance."

Each one of us is a ripple, a center of daring, a small part of the great strength that emanates from within our ranks. We are filled with power, energy, and dreams.

Thank you.

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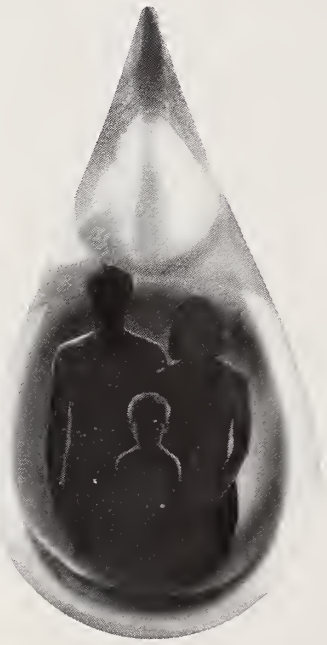

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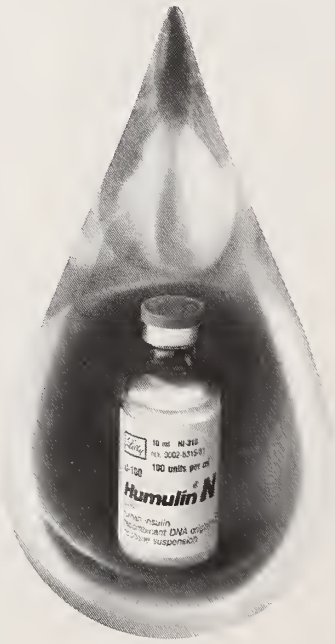

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Medical Liability and Neurologically Impaired Infants: A Special Approach to Handling Claims

Thomas L. Uehlin

Of the many physician and surgeon medical specialties insured by St. Paul Fire and Marine Insurance Company, one of the practices most affected by medical liability claims (including some of the more costly claims) is obstetrics/gynecology. OB/GYN as a specialty *has* seen an improvement in loss experience in recent years. For this reason, in 1988 we lowered the OB/GYN "relativity rating," or the statistical relationship between the risk of a given specialty and a general practitioner. The lowering of the relativity created a slight reduction in rates for OB/GYN practitioners.

In the interest of continually improving loss experience, our risk management services representatives conduct specialized analyses of hospital obstetrics departments and staff, reviewing a wide range of risk factors and making recommendations for improvement where appropriate. Even the best risk management efforts won't prevent all claims from being filed. When that happens, doctors look to their insurance carrier to defend or the resolve the claim.

High Impact Claims

Malpractice suits regarding neurologically impaired infants are among the most difficult, expensive and high-profile claims faced by physicians and insurance companies. Such high-impact cases can have both tangible and intangible effects on physicians.

A good deal of time and effort will be required of the physician in contributing to the defense against the charges. While an individual St. Paul-insured physician's medical professional liability insurance rates will not change because of legal action against the physician, each claim plays a role in the rates all of our insured physicians pay for insurance. The number and costs of claims against physicians are the driving forces in rate determination, and birth-related claims are typically among the most costly.

The intangible effects of being sued also have an impact. The physician's abilities and judgment are questioned. His or her professional reputation may be damaged, sometimes through dramatic media coverage. Finally, there may be physical and emotional repercussions as a result of what can be the long and trying process of defending the claim.

The results of such claims clearly have important implications for both policyholders and insurance companies. During 1987 and 1988, claims classified as improper birth-related treatment represented the second most frequent allegation against St. Paul-insured physicians (after postoperative complications related to surgery), with an average cost of nearly $130,000 (includes total cost of claim, including defense costs and reserves; this figure also includes claims closed without payment). Individual claims of this type frequently cost in excess of $1 million.

Mr. Uehlin is Vice President and General Manager, Atlanta Service Center, St. Paul Fire and Marine Insurance Company.

Send reprint requests to Barry J. Johnson, Senior Communications Specialist, The St. Paul Companies, Inc., 385 Washington St., St. Paul, Minnesota 55102.

Obstetrical Claims

In the late 1970s and early 1980s, our data showed a significant increase in both the number and costs of obstetric malpractice claims. Representatives from our Home Office Claim Division also began noticing variations in the disposition of these often similar birth-related claims.

Our Claim Division, under the guidance of Medical Liability Claim Officer Norm Schindler, therefore conducted a more thorough review of the situation. The files of 30 similar birth-related claims were compiled and individually reviewed. The facts of the claims, the defense and the results were noted. This examination revealed a number of common threads and characteristics upon which these cases turned. As a result, an effort was begun to provide claim representatives and defense attorneys a cutting edge, specialized knowledge of these issues, with the goal of offering the strongest defenses possible of these difficult claims.

Special Handling

Using the findings of this claim review and a compilation of literature on neurologically impaired infants, we began a special program in 1984 for the handling of birth-related claims. The concept divides the country into 14 geographic regions. A "lead attorney" for the handling of these claims is identified in each region, along with a number of "coordinating attorneys." Internally, a limited number of experienced, senior claim representatives in each of the 14 regions were assigned to the effort.

This program was established in part to resist a very simplistic argument being used in many birth-related claims at the time. The basic theory was that if there was an adverse result in a birth, the physician faced liability because he or she did not use a fetal monitor or did not read the monitor strip correctly and, as a result, either did not perform a Caesarean delivery or did not do so in a timely fashion. We believed that a wide range of factors beyond health care provider error was involved in causing neurological impairment of newborns. In 1984, we presented our first seminar for claim representatives and our network of defense attorneys. The seminar examined the handling of cerebral palsy claims and the standard of care issues involved.

An effort was begun in 1984 to provide claim representatives and defense attorneys a cutting edge, specialized knowledge of obstetric issues, with the goal of offering the strongest defenses possible of these difficult claims.

Our goal of countering the argument that physicians were *always* liable for neurologically impaired infants was bolstered by a National Institutes of Health report issue in 1984. The report, "Prenatal and Perinatal Factors Associated with Brain Disorders," examined causes — genetic, infection, congenital — of insults to the brains of fetuses. The report added credence to the concept of brain injuries unrelated to events during delivery.

Training Efforts

Since 1984, additional seminars have been conducted, in which medical and legal experts have made presentations to the participants, providing them specialized information on a wide range of related topics. Fetal monitoring, labor and delivery complications, forceps deliveries, and Caesarean sections are some of the topics that have been examined. In addition, placental pathology, brain maldevelopment, genetic abnormalities, and alternative causes of neurologic impairment were discussed.

The training of defense attorneys and claim representatives is an ongoing effort. In addition to the materials they receive regularly from The St. Paul and the medical community, participants also exchange information informally, building on their own expertise and experiences across the country.

Defense Efforts

In addition to the training provided the network of defense attorneys, our handling of neurologically impaired infant claims includes a number of additional components aimed at enhancing defense efforts. Lead and coordinating attorneys are regularly provided information detailing the lawsuits tried by their colleagues. This information provides insight into the intricacies of defending these specialized claims. Defense counsel also have increased access to medical specialists. Medical professionals in the forefront of various specialties review medical records and consult with counsel. Placental pathologists, pediatric neuroradiologists, dysmorphologists, and other experts can all play important roles in determining the cause (or lack of cause) of a child's neurological impairment.

Malpractice suits regarding neurologically impaired infants are among the most difficult, expensive, and high-profile claims faced by physicians and insurance companies.

An important aspect in handling birth-related claims is the defense response to the plaintiff's request for a specific amount of damages. The amount specified by the plaintiff is likely to be based on a worst-case scenario — a liberal estimate of the amount required for decades of medical care, housing, rehabilitation or training (if possible) and other needs.

Pediatric developmental specialists can be asked to make very specific determinations regarding mental retardation, future abilities and disabilities, the likely success of rehabilitation and training, vocational opportunities, and life expectancy. With these kinds of data, the defense can suggest a very specific and reasonable estimate of damages. In claims where some indemnity payment is likely, this information can be used to formulate a "structured" settlement (such as the purchase of an annuity to cover the cost of the claim).

Our experience in this area has helped counter the concept that neurologic impairment in newborns was clear evidence of medical negligence. In fact, in neurologic impairment claims where insured physicians have saved, examined and documented diseased placentas, we have not lost a single case nationwide.

St. Paul Fire and Marine Insurance Company continues to look for opportunities to help policyholders manage the risks they face and to provide its defense attorneys the information and resources required for cutting-edge knowledge in the area of neurologically impaired infant claims. Over time, such efforts can result in improved loss experience and, ultimately, more favorable professional liability rates.

Georgia Claim Experience Results in Rate Decrease, Retro Refund

Georgia physicians insured by St. Paul Fire and Marine Insurance Company recently experienced a decrease in their medical liability insurance rates. Policyholders during 1988 also received a refund under The St. Paul's Retrospective Premium Plan. In Georgia, the average decrease was 18.4 percent among their 3,600 physician and surgeon policyholders.

Rate Changes

The average paid claim costs (actual payments made to plaintiffs plus defense costs) in Georgia are increasing. In 1984, the average paid claim against all of their insured Georgia physicians was approximately $114,400. The following year, it had risen to $140,900. The cost of the average paid claim dropped slightly in 1986, to $140,200, then rose to $163,900 in 1987. For 1988, the cost of the average paid claim was $194,600.

In Georgia, claim "frequency" (or the number of claims per 100 St. Paul-insured physicians) hit a high of 18.9 in 1984. It dropped to 17.2 claims per 100 policyholders in 1985, and the downward trend has continued. The number of claims filed per 100 physicians in Georgia has been running slightly higher than the countrywide average, with the exception of 1987.

"Retro" Plan

In 1987, The St. Paul introduced the Georgia Retrospective Premium Plan. The plan is a benefit to policyholders, providing for a partial return of premium if, over a period of years, loss experience is better than the experience anticipated when the premiums were calculated. Losses in Georgia have been less than anticipated. As a result, qualified 1988 policyholders (a few large, group accounts have their own separate plans) have received slightly more than $1.8 million in returned premiums.

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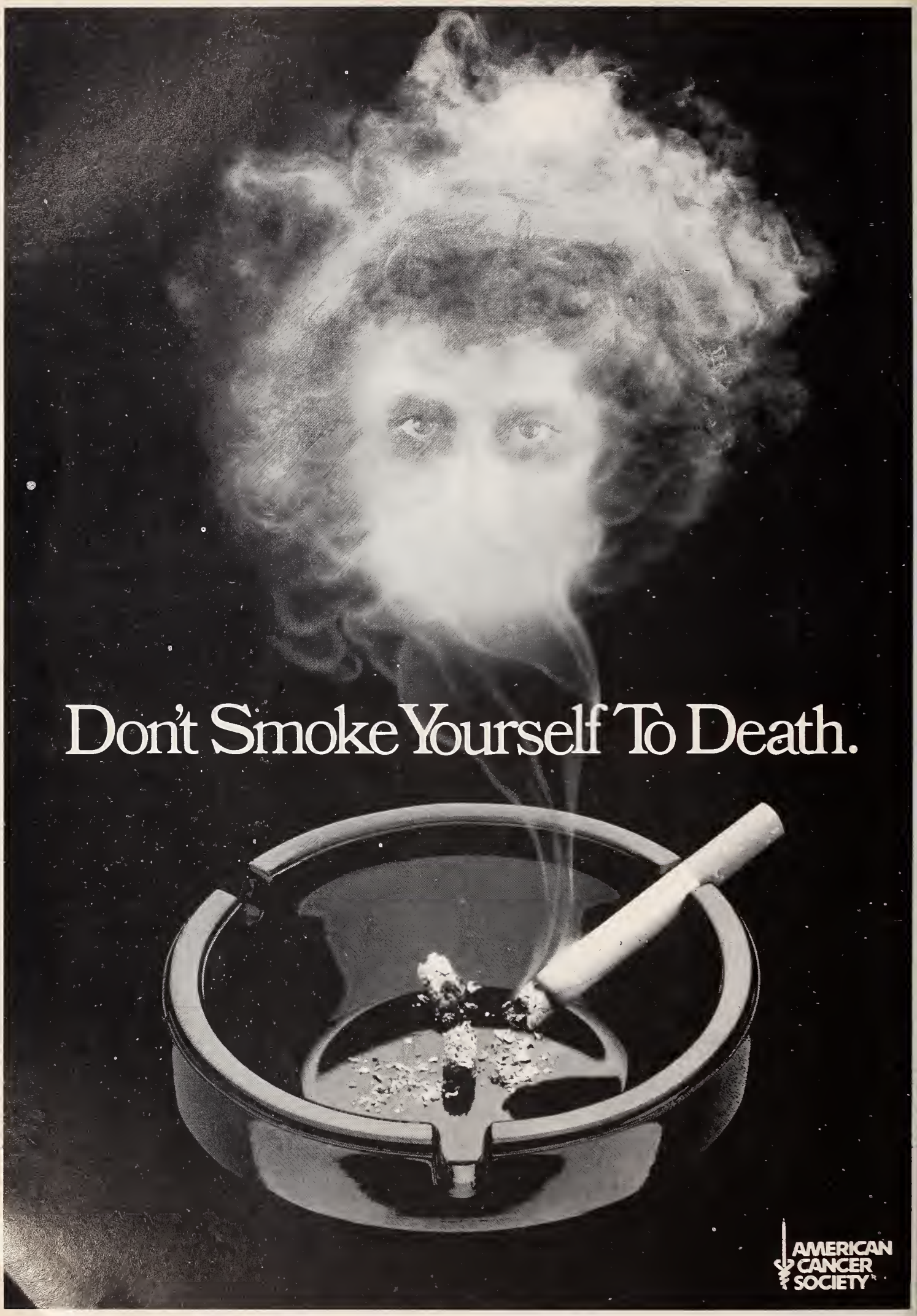
New Heart Section Editor Selected

WE HAVE *recently selected a new Editor for our Heart Section in the* Journal. ***Robert C. Schlant, M.D.,*** *has generously agreed to serve in this capacity, on behalf of the Georgia Affiliate of the American Heart Association (AHA), to obtain timely articles on cardiology of interest to practicing physicians.*

A graduate of Vanderbilt University School of Medicine, Dr. Schlant is currently Professor of Medicine (Cardiology) at Emory University School of Medicine and Chief of Cardiology at Grady Memorial Hospital in Atlanta. He has been extensively involved in several professional associations, including both the AHA and the Georgia Affiliate of the AHA, the American College of Cardiology, the American College of Physicians, and the American Board of Internal Medicine. Dr. Schlant has also served on the editorial boards of many scholarly publications and as editor, associate editor, and editorial consultant of several others. His credentials are most impressive, and we feel fortunate to have him as our new Heart Section editor.

Wesley Covitz, M.D., who served as our Heart Section Editor for the past 3 years, has moved to North Carolina to assume a new position at Bowman Gray School of Medicine. Dr. Covitz was from the Pediatric Cardiology Section at the Medical College of Georgia. He has served us well, and we are indebted to him.

This space contributed as a public service



Dealing With the New National Practitioner Data Bank

Robert N. Berg

PHYSICIANS BY NOW should be somewhat familiar with the immunity provisions enacted as part of the Health Care Quality Improvement Act of 1986[1] (the "Act"). Under the Act, hospitals, physician organizations, and others engaged in professional peer review are provided with immunity from damages under federal and state law, so long as certain standards are met. These standards are designed to ensure that peer review is conducted in a fair and reasonable manner.

Congress was not only concerned about the quality of health care and the need to encourage and improve professional peer review activities. Congress was also concerned over the "national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance."[2] Accordingly, the Act also included provisions creating the National Practitioner Data Bank (the "Data Bank") to collect and release certain information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. Final Regulations ("Regulations") under the Act were recently published[3] by the U.S. Department of Health and Human Services ("HHS"), and in this month's Legal Page, we take a closer look at the nature and scope of the "deposits" and "withdrawals" required and permitted to be made at the Data Bank.

"This month we take a closer look at the nature and scope of the "deposits" and "withdrawals" required and permitted to be made at the Data Bank."

Who Must Report to the Data Bank?

The Regulations require that a wide variety of persons and entities report certain information, directly or indirectly, to the Data Bank. Among those required to report are:

(a) Hospitals.

(b) Other "health care entities," including any entity that provides health care services and engages in *professional review activity* through a formal peer review process for the purpose of furthering quality health care, or a committee of that entity. It also includes a professional society or a committee or agency thereof, including those at the national, state, or local level, of physicians, dentists, or other health care practitioners that engage in *professional review activity* through a formal peer review process for the purpose of furthering quality health care. Under the Regulations, this definition would include health maintenance organizations and any group or prepaid medical or dental practice which meets the above criteria.[4]

(c) Each individual or entity, including an insurance company, which makes a payment under an insurance policy, self-insurance, or otherwise, for the benefit of a physician, dentist, or other health care practitioner in settlement of or in satisfaction in whole or in part of a claim or a judgment against such physician, dentist, or other health care practitioner for medical malpractice.[5]

For purposes of determining the applicability of the reporting requirements, the Regulations define a "physician" as a doctor of medicine or osteopathy; a "health care practitioner" means any individual other than a physician or dentist who is licensed or otherwise authorized by a State to provide health care services. "Professional

This article was prepared at the request of the *Journal*. Mr. Berg is a principal in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Rd., NE, Atlanta, GA 30326. Send reprint requests to Mr. Berg.

review activity" is defined as activity of a health care entity with respect to an individual physician, dentist, or health care practitioner, (a) to determine whether that person may have clinical privileges with respect to, or membership in, the entity, (b) to determine the scope or conditions of such privileges or membership, or (c) to change or modify such privileges or membership.[6]

What Information Must Be Reported to the Data Bank?

Different persons are required to report, directly or indirectly, to the Data Bank, depending upon the type of information required to be reported:

(a) *Medical Malpractice Payments.* As indicated above, certain persons and entities are required to report to the Data Bank insurance payments made in settlement or of in satisfaction in whole or in part of a claim or judgment against a physician, dentist, or other health care practitioner, for medical malpractice. The information to be reported to the Data Bank includes identifying the physician and reporting person, along with information relating to the malpractice claim and the settlement. These reports must be made within 30 days from the date that the payment is made, and the information must be reported simultaneously to the Data Bank and the appropriate state licensing board.[7] HHS apparently intends to develop forms to be used in making required reports.

(b) *Licensure Action.* Each state licensing board is obligated to report to the Data Bank any action taken by that board relating to a physician's or dentist's professional competence or professional conduct. Under the Regulations, this would include licensure revocations and suspensions, censures, reprimands, imposition of probation, and surrendering of licenses. The information required to be reported would identify the physician or dentist and describe the action taken by the board. This information must be reported by the board to the Data Bank within 30 days from the date the licensure action was taken.[8]

"The information to be reported . . . includes identifying the physician and reporting person, along with information relating to the malpractice claim and the settlement."

(c) *Adverse Actions on Clinical Privileges.* Hospitals and other health care entities are required to report any "professional review action" that "adversely affects" a physician's or dentist's clinical privileges for longer than 30 days. In that regard, "professional review action" means an action or recommendation of a "health care entity" (i) taken in the course of professional review activity; (ii) based on the professional competence or professional conduct of an individual physician, dentist, or other health care practitioner which affects or could adversely affect the health or welfare of a patient or patients; and (iii) which adversely affects or may adversely affect the clinical privileges or membership in a professional society of the physician, dentist, or other health care practitioner. (Matters that do not relate to the competence or professional conduct of a physician, dentist, or other health care practitioner, such as those dealing with the practitioner's fees or charges, his or her participation in prepaid group health plans, etc., are excluded from the definition of "professional review action.") The Regulations also indicate that to "adversely affect" means reducing, restricting, suspending, revoking, or denying clinical privileges or membership in a health care entity.[9]

Reports of this type must be made to the state licensing board, which in turn is responsible for providing information to the Data Bank. The hospital or other health care entity also may voluntarily report professional review actions that adversely affect the clinical privileges of limited licensed practitioners. In either case, the information to be reported would identify the physician, dentist, or other health care practitioner involved, together with the actions taken. This information must be reported within 15 days from the date the adverse action was taken.[10]

Persons and entities reporting to state licensing boards and the Data Bank are responsible, under the Regulations, for the accuracy of the information reported, and must promptly submit additional information in order to correct errors or omissions found after the information was originally reported. Moreover, reporting persons must also report any revision of the action originally reported, including reversals of any professional review action or licensure reinstatements.[11]

What Will Happen to the Information Reported to the Data Bank?

The Regulations provide that the Data Bank will hold all information reported to it, for a period of 30 days, in order to afford an opportunity for disputes, corrections, or revisions to be filed, prior to the release of the information. Thereafter, the Data Bank is authorized to provide information to a number of different types of persons or entities, including:

(a) To a hospital requesting information concerning a physician, dentist, or other health care practitioner who is on its medical staff (courtesy or otherwise) or has clinical privileges at the facility.

(b) To a physician, dentist, or other health care practitioner who requests information regarding himself or herself.

(c) To State licensing boards.

(d) To health care entities which have entered or may be entering employment or affiliation relationships with a physician, dentist, or other health care practitioner.

(e) To an attorney or individual representing himself or herself who has filed a medical malpractice action against a hospital, and who requests information regarding a specific physician, dentist, or other health care practitioner who is also named in the action or claim. (This information will only be disclosed by the Data Bank if the hospital failed to request the information from the Data Bank as described below.)

(f) To a health care entity, for purposes of undertaking a professional review activity.

(g) To a person or entity who requests information in a form which does not permit the identification of any particular health care entity, physician, dentist, or other health care practitioner.[12]

In addition to these voluntary types of disclosures, the Regulations also *mandate* that each hospital, either directly or through an authorized agent, must request information from the Data Bank concerning a physician, dentist, or other health care practitioner. This request must be made at the time the physician, dentist, or other health care practitioner applies for a position on its medical staff (courtesy or otherwise), or for clinical privileges at the facility. A request must also be made by the hospital every 2 years concerning any physician, dentist, or other health care practitioner who is on the medical staff of the facility or has clinical privileges at the facility. Any hospital which does not comply with its requesting requirements is presumed to have knowledge of any information reported to the Data Bank concerning the physician, dentist, or other health care practitioner.[13]

What Sanctions May Be Imposed Under the Regulations?

Under the Regulations, the failure to report the insurance settlement of a malpractice claim will subject the person or entity to a civil monetary penalty of up to $10,000 for each such payment. In those situations where a health care entity has "substantially failed" to report an adverse action relating to clinical privileges, the Secretary of HHS is authorized to conduct an investigation and, if a violation is found, the Secretary will publish the name of the health care entity in the Federal Register. In such cases, the immunity protections provided under the Act will not apply to that health care entity for professional review activities that occur during a 3-year period beginning 30 days after the date of publication of the entity's name.[14] Of course, an entity which fails to make a required request would also run the risk of being held liable for negligence, in connection with the credentialing of a physician about whom negative information was on file at the Data Bank.

What Other Provisions Are Included in the Regulations?

The Regulations also include a number of ministerial details relating to the types of reports which must be filed, the manner in which persons or entities may dispute the accuracy of information in the Data Bank, the fees to be paid in connection with obtaining information, etc.

HHS has entered into an agreement with Unisys Corporation, a Pennsylvania-based information systems firm, to serve as the Data Bank. The Regulations will not become effective until the Data Bank is operational and notice thereof is published in the Federal Register.

Notes

1. 42 U.S.C. §§11101-11152 (Supp. 1987).
2. 42 U.S.C. §11101(2).
3. 54 Fed. Reg. 42722 (October 17, 1989), creating a new 45 C.F.R. Part 60.
4. 45 C.F.R. §60.3
5. 45 C.F.R. §60.7.
6. 45 C.F.R. §60.3.
7. 45 C.F.R. §§60.5(a), 60.7.
8. 45 C.F.R. §§60.5(b), 60.8.
9. 45 C.F.R. §60.3.
10. 45 C.F.R. §§60.5(c), 60.9.
11. 45 C.F.R. §60.6.
12. 45 C.F.R. §60.11.
13. 45 C.F.R. §60.10.
14. 45 C.F.R. §60.9.

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Radiation Therapy of Pure Seminoma of the Testicle

Thomas W. Phillips, M.D., Dale L. McCord, M.D., May M. Abdel-Wahab, M.D.

Abstract

AN ANALYSIS of 45 patients with seminoma of the testis treated at the Radiation Oncology Department of Crawford Long Hospital of Emory University, from 1975-1986. Thirty patients with Stage I and II pure seminoma received prophylactic irradiation to the mediastinum and supraclavicular area in addition to receiving periaortic and pelvic irradiation alone. The only recurrence in the supraclavicular region was in a Stage I patient not receiving mediastinal and supraclavicular prophylaxis. No recurrences were observed in Stage II patients. The observed actuarial 5-year disease-free survival of all patients was 91.2%. In patients with Stage I disease, the actuarial 5-year survival was 93.3%. The actuarial 5 and 10-year survival of Stage II patients was 100%.

Introduction

PURE SEMINOMA constitutes approximately 40% of germinal cell testicular cancers.[1] They have been known to be highly radiosensitive, hence the importance of the radiotherapeutic management of seminoma.

Several reports on series of patients treated with radiation therapy after orchiectomy for pure seminoma have appeared over the years. Most of these reports have attempted to determine the extent of radiation to the uninvolved lymph node regions. Several conflicting recommendations for the radiotherapeutic management of seminomas resulted. In some studies, radiation therapy for Stage II seminomas was limited to lymph node bearing regions below the diaphragm.[2,3] In others, irradiation of supradiaphragmatic lymph node areas was recommended in Stage II disease.[4-6] In Stage I, however, most studies recommend limiting irradiation to below the diaphragm.[3,4,6-8] Still, others like Maier, et al. suggested sequential irradiation of the mediastinal and supraclavicular areas in Stage I disease, to 20 Gy, following the infradiaphragmatic nodal irradiation.[9]

From the Department of Radiation Onocology, Crawford W. Long Hospital of Emory University, Atlanta, GA. Address reprint requests to Dr. Phillips, Director, Radiation Oncology Department, 25 Prescott St., Atlanta, GA 30365.

This Department is sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute articles should send them to the Cancer Department Editor, Dr. Tom Phillips at the above address.

Patients and Methods

Patients treated at the Radiation Oncology Department of Crawford Long Hospital of Emory University between the years 1975 and 1986 were analyzed. The diagnosis of seminoma was made by histologic study of the radical orchiectomy specimen. Further staging procedures included chest x-rays or chest tomograms,

intravenous pyelography, CAT scans or bipedal lymphography. Blood chemistries were done for all patients and serum markers (BHCG and Alpha Feto protein) for the more recent patients.

The patients were treated with either 10 MV photons or Co60 irradiation. The average dose to the inguinal, iliac, and periaortic nodal areas was 28.5 Grays (ranging from 13-35 Gy). Treatment was delivered through anterior and posterior opposing fields, with a mid-plane dose of 180-200 cGy per fraction.

Forty-five patients were treated during this interval. A retrospective staging system was used as follows:

1) Stage I: Tumor confined to the testis, spermatic cord, or coverings
2) Stage II: With retropertioneal or iliac (regional) disease below the diaphragm which was detected radiographically (A) or was palpable (B)
3) Stage III: Lymph node enlargement above the diaphragm involving the mediastinum and/or supraclavicular region.
4) Stage IV: Visceral metastatic disease (e.g., liver, lung, bone)

Table 1 — Type of Treatment for Testicular Seminoma, By Stage

	Mediastinal and PAN		*Iliac, inguinal and para-aortic nodal irradiation*	
	No.	*%*	*No.*	*%*
Stage I	8/8	100	6/7*	85
Stage II	22/22	100	1/1	100
Stage III	2/3†	67	1/1	100
Stage IV	none		1/2	50
TOTAL	32/33	97	9/11	82

* Patient developed AIDS and supraclavicular nodal recurrence
† Patient was found to have embryonal carcinoma

Results

The vast majority of our 45 patients were found to be in the early stages of disease (33% Stage I and 51% Stage II). The mean age was 42.34 years (ranging from 26-69). Right and left testes were affected with equal frequency, and a history of cryptorchidism was found in approximately 15% of patients. Orchiectomies were done in 44 patients. The remaining patient had a laparotomy and was found to have extensive abdominal disease (metastatic to the spleen and stomach), so no further surgery, other than a splenectomy, was done.

Approximately half the Stage I patients received irradiation to intra-abdominal lymphatics alone (7 of 15 patients, 47%), and the rest received prophylactic mediastinal and supraclavicular irradiation as well. Almost all Stage II patients received irradiation to both infra and supra-diaphragmatic lymph node bearing areas (22 of 23 Stage II patients. All Stage III patients received chemotherapy as well as irradiation. Three of four received mediastinal and supraclavicular irradiation; the remaining one received only infradiaphragmatic lymph node irradiation (Table 1). All patients had a minimum follow-up of 3 years (range 3-12 years), with an average follow-up of 7.5 years.

At 5 years, an observed actuarial survival of 91.2% was noted. A 93.3% 5-year survival for Stage I was found.

The single failure in a Stage I patient occurred due to the development of AIDS followed by subsequent supraclavicular lymph node recurrence (1½ years after initial treatment). The remaining three failures that occurred in the studied group were either in patients with Stage III (one patient) or Stage IV (2 patients) disease and were due to disseminated disease. The 5-year actuarial survival in Stage II was 100% with no failures. The small number of patients with Stage III and IV disease rendered them unevaluative. It is of importance to note that if recurrences or death due to disease occurred, it was in the first 2 years post treatment.

"When Stage I patients did not receive mediastinal irradiation, a mediastinal recurrence rate of about 8% was observed."

Discussion

Prophylactic irradiation to uninvolved lymph node regions in seminoma is based on the fact that seminomas progress in an

orderly fashion through the lymphatics and adjacent tissue. Furthermore, the dose needed to sterilize microscopic metastases to the lymph nodes is low due to the unusual radiosensitivity of pure seminomas. In view of the ease of controlling any disease that may be present with minimal morbidity, many authors advocate prophylactic irradiation of the mediastinum and supraclavicular lymph node regions in Stage II disease.[4-6] Some even advocate its use in Stage I, although this is not encountered as often.[9] In assessing failure in certain series not choosing to utilize such a technique, it is felt that this type of prophylaxis should always be used in Stage II and may be beneficial even in Stage I disease. In this and in several other series, no recurrence was found to occur supradiaphragmatically when those lymph nodes were treated prophylactically.[7, 10] On the other hand, when Stage I patients did not receive mediastinal irradiation, a mediastinal recurrence rate of about 8% was observed.[11, 12]

"The value of low dose mediastinal prophylaxis and the efficacy of radiation therapy in the cure of pure seminomas is clearly demonstrable."

Furthermore, of 212 Stage I patients, Maier, et al. found that the five deaths that occurred in the group not receiving prophylaxis to supradiaphragmatic lymph nodes occurred due to mediastinal recurrences.[10] The two deaths in the group receiving mediastinal irradiation were due to distant metastases. Nevertheless, other studies show that mediastinal prophylaxis may not always be beneficial.[13]

In conclusion, the decision either way is carefully weighed and depends on the projected improvement in the rate of relapse and survival, as well as the complications. In our particular study, where only one supraclavicular failure occurred in an unirradiated Stage I patient and none in Stage II patients, the value of low dose mediastinal prophylaxis and the efficacy of radiation therapy in the cure of pure seminomas is clearly demonstrable.

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QUOTES

Love at first sight is only realizing an imagination that has always haunted us; or meeting with a face, or figure, or cast of expression in perfection that we have seen and admired in a less degree or in less favorable circumstances a hundred times before.

WILLIAM HAZLITT:
The Prose Album, 1829

Be what nature intended you for, and you will succeed; be anything else and you will be ten thousand times worse than nothing.

SYDNEY SMITH

I Resolve

To strive to contribute something to the world, its work and the people in it.
To spend and be spent in worthy service.
To adhere, the best I can, to the Golden Rule.
To philosophize more, recalling always, when things go awry, "This, too, will pass."
To try always to see viewpoints other than my own.
To make humility and simplicity so much a part of myself that I shall become as a child, as one of those of whom the Master declared, "For of such is the kingdom of heaven."

B.C. FORBES

It's just as unpleasant to get more than you bargain for as to get less.

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> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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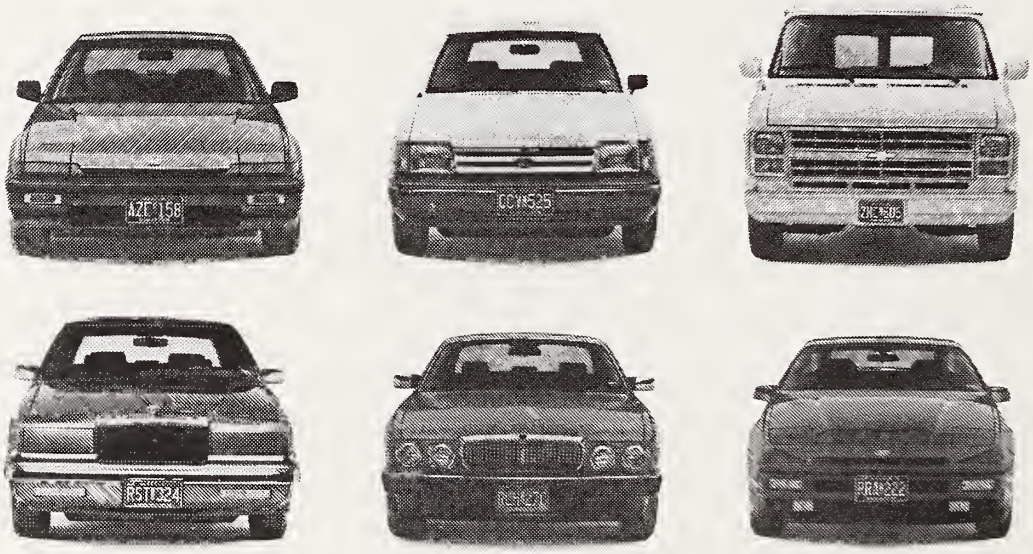

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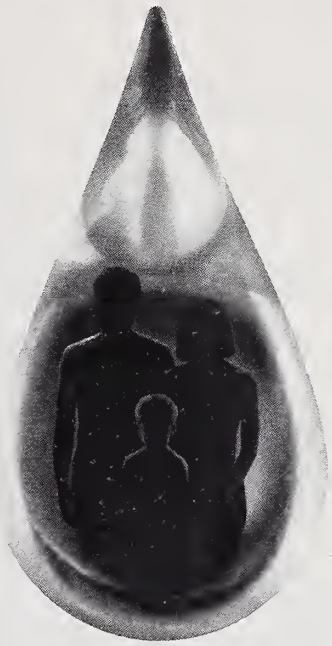

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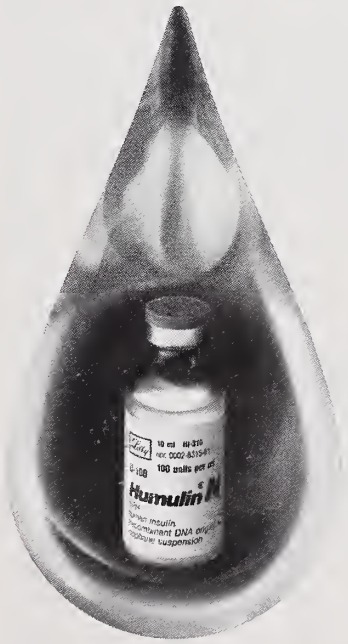

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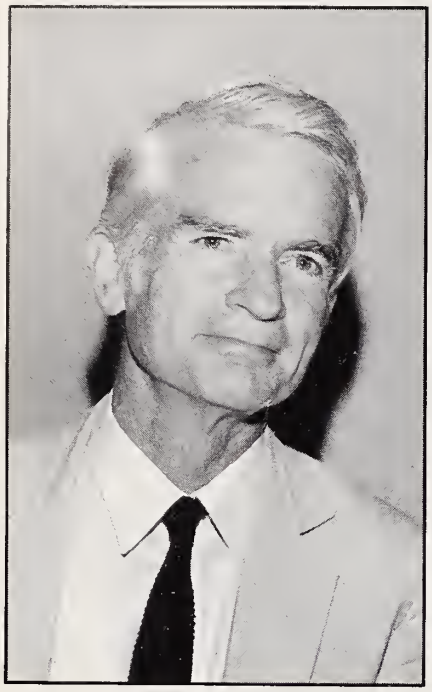
THE COVER

"Generation, Generation" by David Fraley. Read more about this cover art and the artist on page 205.



Reflections

THIS IS MY LAST opportunity to write for this "President's Page," and I have wrestled with the myriad topics that I would like to address.

This issue of the *Journal* focuses on the Auxiliary, which, under the current leadership of Grace Walden, is one of the finest examples of medical spouse support of any state in the union. I expressed my appreciation for this group in a prior article (September, 1989).

Preventive medicine is one of my chief concerns, especially with regard to how we as physicians can better serve our patients by setting an example of a healthy life-style. By abstaining from smoking, avoiding extra salt in our diets, and exercising regularly (i.e., brisk walking, jogging, bicycling, or swimming), we can do more for our health and well being than all of the medications on the drugstore shelves. Our patients and friends are watching our life-styles and what we practice privately has much influence.

Another topic I would like to discuss is harmony between our state organization and its local component societies. During this past year, I have traveled extensively throughout the state, going everywhere anyone would have me. I have learned much and have been impressed with the quality of medicine that is practiced in Georgia.

I also need to pay tribute to the outstanding staff of the Medical Association of Georgia. Just the number of hours spent bird-dogging Aetna and HealthCare Compare justify our dues. The staff has also worked prodigiously in the legislative arena, in public relations, in education, and in innumerable other ways. We are indeed blessed by such an outstanding staff.

Last night as I was trying to decide which of these themes to develop for this my last President's Page, I received a long distance call from Rochester, Minnesota. It was from Tom Hartman, a resident in Radiology at the Mayo Clinic. Tom wanted to let us know that his father, Glen, was succumbing to the final stages of leukemia and would not likely make it to our yearly family rendezvous in the Colorado mountains in March. Glen Hartman, besides being a great friend, is truly an outstanding physician and a tribute to the medical profession. He has headed the Radiology Department at Mayo Clinic and is known internationally for his efforts in renal radiology. His family and mine grew up together and are still quite close. Glen Hartman will always be remembered by me not for his contributions to radiology, but for his fine attributes as a friend.

Surveys show that the medical profession image may be slipping, but that patients still hold their own personal physician in great esteem. The best thing that we can do to enhance the profession's image is to individually practice the best medicine possible, and live our lives to the maximum.

Joe Nettles

Proud to Be Auxilians!

As I HAVE TRAVELLED about the state this year, I am more convinced than ever of the appropriateness of our theme for 1989-90. Auxilians have been hard at work in their local communities — volunteering and fundraising, as well as improving the image of medicine.

MEMBERSHIP: Our membership team has been very successful this year recruiting new members, retaining current members, and organizing new auxiliaries. The Membership Committee has been chaired by Nancy McCord, who has had several years' experience in this field. The area vice-presidents are members of this committee, and they have been in frequent personal contact with auxiliaries throughout the state to boost our membership to an all-time record. In addition, we have had Resident Physician/Medical Student Spouse Liaison coordinators, Sarah Nettles and Ann Claiborne Christian, working to get spouses of medical students and residents into our Auxiliary.

LEGISLATION: We have been recognized nationally by the AMA for our legislative efforts in Georgia. We have a model Phone Bank second to none in its organization and effectiveness. County Auxiliaries especially did a great job of calling their legislators when contacted by the State Auxiliary.

This year for the first time, the Communications and Networking Chairman, Sunny Washburn, encouraged Executive Board Members to send greeting cards to their legislators.

Our MAG Liaison, Wilma Tillman, has kept us informed about MAG's legislative needs.

The legislative event of the 1989-90 year was the Tour of Historic homes and luncheon in Macon, co-sponsored by the Auxiliary and the Medical Association of Georgia. This event was requested by the legislators' wives, and they were our guests in Macon. We were happy to oblige, because, "A happy legislative family is a friend of medicine!"

HEALTH PROJECTS: Each county auxiliary was encouraged to select health projects appropriate to their areas, but of particular emphasis this year has been the (1) O.P.A.L.S. program, (2) Anti-Smoking programs in schools, (3) Support Liaison groups, and (4) Safety project. Information about these projects was presented last year at the State Executive Summer Board Meeting. Several county auxiliaries developed and presented a county Teen Health Forum this year. Since this was a state forum in 1988-89, we are pleased that some counties found it prudent to reach out to more teenagers within their counties with this message of healthy life styles.

The O.P.A.L.S. program (Older Persons with Active Life Styles) was initiated statewide this year to encourage older persons to continue to be active participants in life and to have healthy life styles. This is especially pertinent since more people are living longer than ever. Also, MAG promoted a statewide Medicare education program this year to physicians and the general public, so the Auxiliary was especially pleased to have its O.P.A.L.S. program in progress the same year.

AMA-ERF: The contributions to the American Medical Association's Education and Research Foundation were encouraged through various fundraisers (statewide and locally) and through physicians' contributions to their medical schools. Our Auxiliary always raises a record amount of money for this worthwhile cause.

This year has been a successful one in all endeavors because of team efforts! It has taken all auxilians working together to bring about such impressive results. I would like to take this opportunity to publicly thank members of the AMAG Executive Board and each County auxilian for working so hard in your support of our State Auxiliary in 1989-90. We could not have reached our goals without you. We hope you will continue to feel that the Auxiliary is the greatest support group you have. Thank you! I'm Proud to be an Auxilian!

Grace Walden
President, A-MAG

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Sulieman, Subhi I., Nephrology — Bibb — (Active N2) 671 Hemlock St., Macon 31201

Tsai, Stella I., Neurology — Bibb — (Active) 389 Mulberry Street, Macon 31201

Turk, Paul G., Anesthesiology — Bibb — (Active N2) 380 Hospital Dr., Ste. 465, Macon 31201

Wheatley, Susan J., Obstetrics/Gynecology — MAA — (Resident) 1790 Northside Dr., N.W., Apt. 314, Atlanta 30318

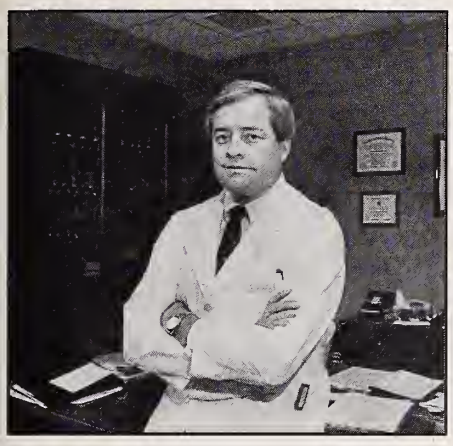
Williams, Benjamin P., Internal Medicine — Upson — (Active N2) 202 Cherokee Rd., Thomaston 30286

PERSONALS

Medical Association of Atlanta

Thomas W. Phillips, M.D., a radiation oncologist, was elected to Fellowship in the American College of Radiology. Dr. Phillips is serving a 2-year term as president of the American Cancer Society for the state of Georgia. He is the medical director of radiation oncology department at Crawford Long Hospital as well as chairman of the Crawford Long Cancer Committee and Tumor Registry. Dr. Phillips also serves as Editor of the *Journal's* Cancer Department. He is the president

of the Georgia Radiation Oncology Society.



▼ **Julius Ehik, M.D.,** Clinical Director at Ridgeview Institute in Atlanta, was recently presented with the 1990 Distinguished Service Award by the Georgia Chapter of the American Association of Psychiatric Administrators.

▲ **William F. Thorneloe, M.D.,** has assumed the position of associate program director for Ridgeview Institute's Adult Psychiatric Treatment program. Dr. Thorneloe is a graduate of Clemson University. He attended the Medical College of Virginia and completed his residency in psychiatry at the University of Alabama at Birmingham.

DEATHS

H. Bagley Benson, M.D., of Atlanta, a pediatrician for more than 50 years, died last February of cancer at the age of 78.

Dr. Benson practiced medicine until his retirement last September. He received a Certificate of Distinction from the Medical Association of Georgia for his half-century of service.

A graduate of Emory University, he received his degree from the Emory University School of Medicine. He interned at Grady Memorial Hospital and completed his residency at Willard Parker Hospital in New York City.

Dr. Benson was a captain in the Army medical corps in World War II, serving in England. He was a former volunteer at the Fulton County Health Department's tuberculosis clinic, and he was cited for work at the Georgia Heart Association clinic.

Carter Smith, Sr., M.D., of Atlanta, a former Piedmont Hospital board chairman, died of a stroke. He was 86.

Dr. Smith, a specialist in internal medicine and cardiology, was chairman of the hospital's trustees from 1968 to 1973 and chairman of its department of medicine from 1951 to 1966.

He also was a clinical professor of medicine at Emory from 1960 to 1986. He and J. Willis Hurst, M.D., of Emory University School of Medicine worked out a 1970 agreement setting up a postgraduate educational program at Piedmont Hospital for Emory students, residents, and cardiac fellows.

In 1941, Dr. Smith was one of two doctors who nursed World War I flying ace and Eastern Airlines President Eddie Rickenbacker back to health after the crash of an Eastern DC-3 near Morrow, which killed eight people.

Dr. Smith had a national reputation in his field and was a former chairman of the Board of Examiners for cardiovascular diseases of the American Society of Internal Medicine. He was made a Master of the American College of Physicians and received an Award of Honor from the Emory alumni, both in 1973.

In 1984, a former patient donated $1 million to set up a professorship in Dr. Smith's name in the Emory University School of Medicine.

Dr. Smith was a former chairman of the Piedmont Hospital Foundation; a former vice president and governor for

Georgia of the American College of Physicians; a former president of the American Heart Association, Georgia Affiliate; and a former member of three Emory University committees of boards — the Medical School Admission Committee, Medical School Scholarship Committee, and Board of Visitors.

Gainesville internist **A. Fredrick Bloodworth, M.D.,** died in January following a brief illness. He was 63. Dr. Bloodworth had practiced from 1957 until his retirement in 1985. He was a member of both local hospital staffs and medical director of respiratory therapy at Lanier Park Hospital. He was also a member of the board of trustees for Lanier Park Hospital.

Dr. Bloodworth received his undergraduate education at North Georgia College and the University of Georgia and his medical degree from the Medical College of Georgia in 1950.

He was past president of the American Lung Association of Georgia, the Georgia Thoracic Society, and the Georgia Chapter of the American College of Chest Physicians. He served 6 years on the National Council of the American Thoracic Society.

OTHER NEWS

AMA Membership Incentive Award

This year, MAG will be awarded $16,745 for increasing 1989 AMA membership over the previous year. This is the first time we have received this award. All MAG members are urged to remit have their AMA dues through the MAG headquarters office rather than sending AMA dues directly to Chicago. All AMA dues processed through MAG are tallied at year end, and MAG is eligible to receive the award from AMA for membership increases. AMA bills members direct when dues are not received promptly, but please send your AMA dues through the MAG office so we can keep a record of your AMA membership, so we can receive AMA's Membership Incentive Award *again!*

QUOTES

Why can't we build orphanages next to homes for the aged? If someone's sitting in a rocker, it won't be long before a kid will be in his lap.
CLORIS LEACHMAN

I have a very strong feeling that the opposite of love is not hate — it's apathy.
LEO BUSCAGLIA

We abuse land because we regard it as a commodity belonging to us. When we see land as a community to which we belong, we may begin to use it with love and respect.
ALDO LEOPOLD

The great need for anyone in authority is courage.
ALISTAIR COOKE

Praise is the best diet for us, after all.
SYDNEY SMITH

An ounce of performance is worth more than a pound of preachment.
ELBERT HUBBARD

Faith is believing that something will be, or is!
STEPHEN KING

Censure is often useful, praise is often deceitful.
WINSTON CHURCHILL

Agreement makes us soft and complacent; disagreement brings out our strength. Our real enemies are the people who make us feel so good that we are slowly but inexorably pulled down into the quicksand of smugness and self-satisfaction.
SYDNEY J. HARRIS

Little progress can be made merely attempting to repress what is evil. Our great hope lies in developing what is good.
CALVIN COOLIDGE

When the fight begins within himself, a man's worth something.
ROBERT BROWNING

Nothing has an uglier look to us than reason, when it is not on our side.
GEORGE SAVILE

Life offers itself equally to the small and the great, the weak and the strong.
ALEXIS CARREL

When put to the test, an ounce of loyalty is worth a pound of cleverness.
ELBERT HUBBARD

Preposterous ass, that never read so far to know the cause of why music was ordained; was it not to refresh the mind of man after his studies or his usual pain?
SHAKESPEARE

If you want enemies, excel others; if you want friends, let others excel you.
CALEB C. COLTON

Little drops of water wear down big stones.
RUSSIAN PROVERB

Success is not searching for you. You must do the seeking.
FRANK TYGER

Today's Auxiliary

MaryAnn W. Marks

'Auxiliary members are spirited advocates of the physician and the practice of medicine and greatly concerned about public sentiment.'

TODAY'S AUXILIARY to the Medical Association of Georgia is a large, purposeful, goal-oriented organization made up of physicians' spouses who are eager to serve their communities. They are proud to be involved in a partnership committed to guarding and improving health care and the quality of life for those they serve. As responsible partners, Auxiliary members in Georgia are dedicated to promoting health projects and health education programs in all segments of our population, and to providing untold volunteer hours in activities that meet health needs.

Legislatively, the Auxiliary plays a vital role in involving MAG members and their spouses in working on legislative issues that affect the practice of medicine and the delivery of health care in our state and nation. The Phone Bank Program, organized and implemented by the Auxiliary at the request of MAG, has been recognized nationally and now serves as a model for other states.

Auxilians are interested in fundraising — always accomplished in creative and entertaining ways, to the extent that it benefits AMA-ERF, health projects, scholarship funds, and student loan programs.

Auxiliary members are spirited advocates of the physician and the practice of medicine and greatly concerned about public sentiment.

Auxiliary membership is both a privilege and a responsibility. It is also voluntary. Great effort is expended in attracting new members. Programming is constantly being updated in an effort to meet expanding needs and interests, and to motivate members into active involvement in Auxiliary work. Membership recruitment and effective programming are on-going goals.

Today's Auxilians may be found on city councils and county commissions or serving on School Boards, all in elected capacities. They assume leadership positions in cultural undertakings and are concerned with conserving natural resources and protecting our environment. Many have careers or professions of their own, and still others achieve high academic success. All of this they balance with well run homes and beautifully attended children, and still find time to be involved in their churches and synagogues, to take their turn in night shelters and soup kitchens, to work in PTAs and parent organizations, and to support community and civic projects. They are also caring members of the "medical family," ever mindful of the pressures and problems common to us all.

Proud to be Auxilians? Indeed, we are! ■

MaryAnn Marks (Mrs. Thomas W.) served as guest editor of this issue of the *Journal*, working with auxilians around the state to obtain interesting and informative articles to present to MAG *Journal* readers.

Society to L & D . . . Stat!

Murray A. Freedman, M.D.

Marshwinds Publications, 1988

THIS BOOK has as its stated purpose to inform patients as to why the author stopped doing obstetrics and to inform the public that the malpractice crisis is real, will impact on the quality of care, and needs public action. In the explanation to patients, there are glimpses of the inner agony of a caring physician as he makes a decision to stop doing part of what he had trained so many years to do and loved doing despite the hours and fatigue. This part of the book had deep meaning for the reviewer and should also arouse empathy in women who have had babies.

"The author presents an obviously heartfelt concern for the quality of health care and gives his fears about what is happening to it."

The parts of the book that concern medical malpractice litigation probably will not elicit empathy from plaintiff's lawyers. Although the author lists and describes many of the ills of the medical profession, he does dwell on the ills of the legal system, presents them from the emotional perspective of a victim of the system, and some unfair comments occur. In today's courtroom, a defendant's lawyer should protect his or her client from any aggressive attorney that tries to use the old movie cliche "answer yes or no." Despite the presentation of the material with emotional bias, the author has an important message for the public. From where he stands, he can see the potential for serious decline in the quality of medical care, first as a result of the crisis in obstetrics, then with medicine in general as the more talented young people go into other professions.

The author presents an obviously heartfelt concern for the quality of health care and gives his fears about what is happening to it. But will one small book have enough impact on the public to prevent a crisis?

Joseph R. Swartwout, M.D.
F.A.C.O.G., Macon

DR. MURRAY Freedman dedicates *Society to L & D . . . STAT!* to his patients. The book is Dr. Freedman's explanation of why he quit obstetrics and is a call for reform of the medical malpractice system.

Dr. Freedman has a private practice in Augusta and a clinical position at the Medical College of Georgia. He begins his book by contrasting the hopes that led him into obstetrics and gynecology with the stresses placed on him by patients' expectations that all deliveries will be normal and simple and that all babies will be healthy.

The triumph of the book is Dr. Freedman's account of his anger and hurt upon being sued for malpractice. The doctor recounts in vivid detail his pain, fright, and loneliness. Both lawyers and patients need to read Chapter Four to feel the horror of a doctor who practices good medicine and commits no error, but still ends up the defendant in a medical malpractice lawsuit. Dr. Freedman's account is vivid. He captures the anguish of feeling that the world will consider him guilty until proven innocent. He mocks the hollowness of his lawyer's advice "don't take it personally" — when the charge is most personal.

Dr. Freedman then goes on to list his complaints about the medical malpractice system. While the list is lengthy, his two central

concerns are plaintiff lawyer's contingency fees and high jury awards for damages. Dr. Freedman's recommendations for reform are modeled on the American Medical Association's proposal for a Medical Malpractice Review Board. Rather than submitting medical malpractice claims to the court and juries, claims should be decided by a panel of physicians and lay people. Plaintiff lawyers should not be allowed to use contingency fees.

"The triumph of the book is Dr. Freedman's account of his anger and hurt upon being sued. He recounts in vivid detail his pain, fright, and loneliness."

Near the end of the book Dr. Freedman says, "It has been therapeutic for me to write this book because I have vented some frustration." Regrettably, most of Dr. Freedman's frustration gets vented as *ad hominem* attacks on lawyers: greedy lawyers file frivolous lawsuits; greedy lawyers seek huge jury verdicts so they can keep most of the money for themselves; and medical schools teach doctors to be ethical, while law schools teach lawyers to be tricksters.

I was asked to review Dr. Freedman's book because I am an academic lawyer who teaches Health Care Law at Mercer Law School. Our entire tort system, including medical malpractice, needs reform. Regrettably, Dr. Freedman's overly zealous attack on the legal profession does not encourage the dialogue that is the necessary prerequisite to constructive change.

Dr. Freedman's graphic account of his pain upon being sued for malpractice reminds patients and lawyers that all doctors are not bad. Rather, most doctors are good practitioners. Maybe now that Dr. Freedman has vented his anger by writing this book, he can admit that not all lawyers are bad. Malpractice reform needs all parties — doctors, patients, *and* lawyers — working together to create change.

"Regrettably, Dr. Freedman's overly zealous attack on the legal profession does not encourage the dialogue that is the necessary prerequisite to constructive change."

Sidney D. Watson, J.D.,
Harvard Law School
Assistant Professor of Law
Mercer University School of Law

Highlights of MAG's 1990

Leadership Conference

THE "PRO" AND "CON," teamed up — A highlight of Saturday morning's program was the debate between Mrs. Vita Ostrander (left) and Dr. Joe Bailey (center) on "Why Mandatory Assignment in Georgia?" President Nettles is shown on the right. As Past President of the American Association of Retired Persons Mrs. Ostrander said the AARP supported mandatory assignment so long as the elderly's access to health care would not be jeopardized. Dr. Bailey called mandatory assignment "a non-American discriminatory yoke on the physician, placing him in a form of serfdom and potentially destroying the future of medicine and our great profession."

STATE REPRESENTATIVE Johnny Isakson of Marietta helped get our program underway with his participation in our Governor's Candidate Forum.

JUDGE GREELEY Ellis, one of two Republican contenders (with Representative Isakson) for the governorship, who joined us at the MAG Conference.

STATE REPRESENTATIVE Lauren "Bubba" McDonald, a native of Commerce, one of the gubernatorial contenders speaking at our candidate forum.

STARTING OFF our program on Saturday, February 3 was the Medical Association of Georgia's 1990 Gubernatorial Candidate's Forum. Shown here are Mrs. Shirley C. Miller, who represented the Lieutenant Governor, and State Senator Roy Barnes of Mableton. MAG was fortunate to have four candidates, plus Mrs. Miller. Former Mayor Young of Atlanta had planned also to join us, but was called to other duties in preparation for his formal campaign announcement, February 5.

◀ *DR. CHARLES UNDERWOOD, (R) Editor of the* Journal of the Medical Association of Georgia, *was chatting with Steve Sternberg when we asked for a pose. Mr. Sternberg, Medical Writer for the Atlanta* Journal-Constitution, *spoke on "How We Report Medicine in the Atlanta Newspapers — And How You Can Help."*

▲ *"IN THIS COUNTRY, every person every morning brushes the teeth of the human being who is morally responsible for the future of the United States," declared United States Congressman Newt Gingrich, Keynote Speaker for MAG's 1990 Leadership Conference. "Each one of you has a moral obligation to be involved," said Rep. Gingrich, as he urged physicians to bolder activity in the political process. We emphasized GaMPAC, MAG's political action fund: "If you don't give at least as much to GaMPAC as you give to your most expensive single hobby, then you deserve what you get."*

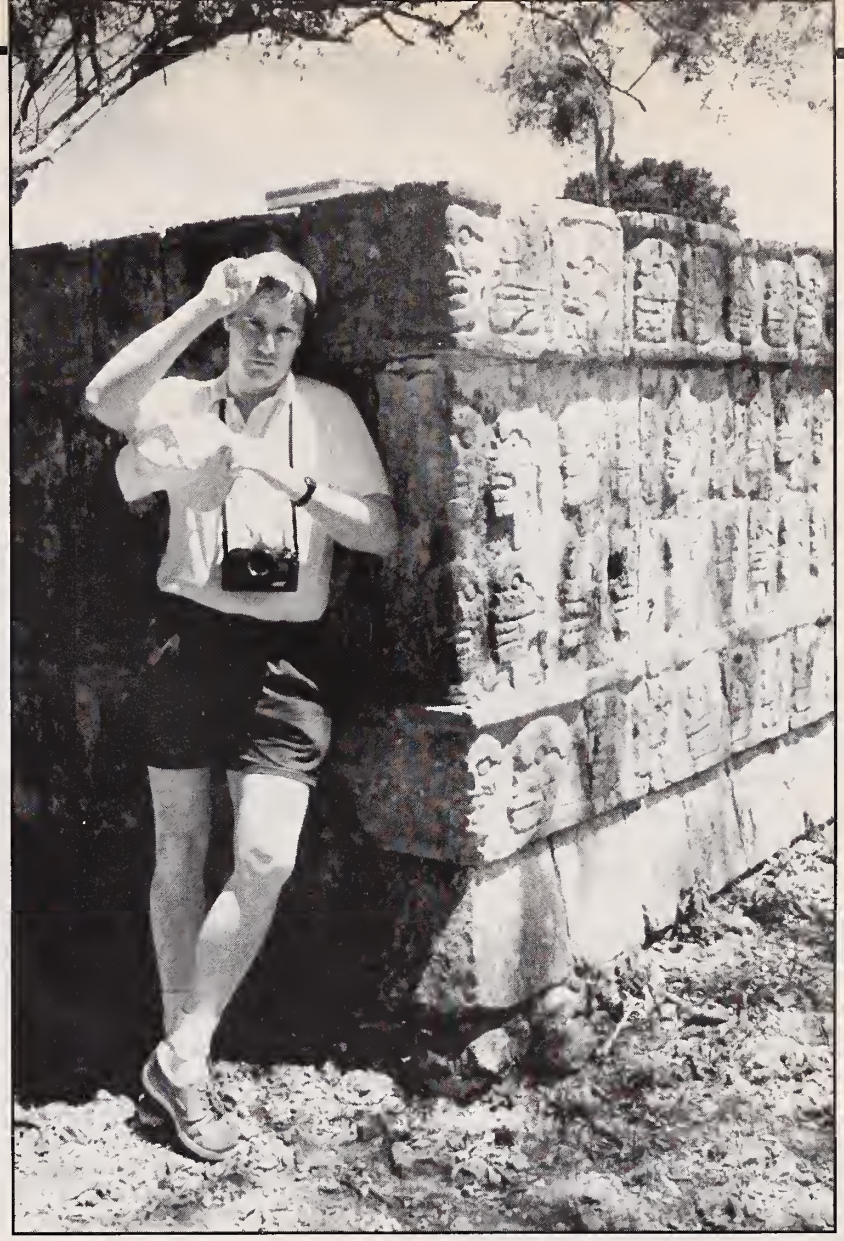
VO VIP'S IN THE AMA — Dr. Harrison Rogers, Past President of the American edical Association (left) and Dr. James S. Todd, Senior Deputy Executive Vice esident of the AMA. Dr. Todd's address, entitled, "Fighting to Save the Best of edicine: or 'ET, Go Home!,' " brought us up to date on the AMA's fight against e Administration's plan to implement "expenditure targets" (ETs) in the federal eatlh care budget, as a means of cost-control.

THERE WERE LOTS of Q/A all day, after our speakers. Here Dr. Jeff Nugent and Dr. Louis Felder of Atlanta line up behind a floor mike, followed by Dr. Charles Hollis of Albany (behind Dr. Felder), and Dr. John Ed Fowler of Clayton.

MAG's "TOWER OF POWER," legislatively speaking. From left: Richard Greene, Director of Governmental Affairs and General Counsel; Dr. Jim Kaufmann, Chairman of our Legislative Council; and Joe T. Wood, former state representative and MAG's Legislative Consultant. After lunch on Saturday, Mr. Green and Mr. Wood provided a brief update on legislative activity in the General Assembly, then entering the fourth week of the 1990 Session.

About the Cover Artist

David Fraley



About the Cover

WEBSTER defines synergy (from the Greek *syngeros*, working together) as the "cooperative action of discrete agencies such that the total effect is greater than the sum of the effects taken independently." Such is an apt description of the cooperative efforts of the Auxiliary and the MAG which expand for the greater good of patients and physicians throughout Georgia. The cover art by David Fraley symbolically suggests this volunteer synergy.

Mr. Fraley describes his work as being concerned with a longing for authentic community, intimacy, and transcendence in a culture whose priorities often work against those goals. These longings are expressed in tone and metaphor most frequently described as whimsical, nostalgic, mischievous, and erotic.

The work reproduced on the cover, "Generation, Generation," deals specifically with how the individual weaves his/her part through the fabric of community, participating in the tapestry of history. The more aware we become of our participation in a universal community, the more care we will take about our individual choices. If we really believe that our actions will in some way affect the universal Dance, we will *want* to act more responsibly. Certainly the activities of the Auxiliary and MAG are part of that responsible action.

About the Artist

DAVID KENNARD FRALEY was born in 1952 near San Francisco and raised principally in Germany and rural New Mexico. At the age of 8, he began private instruction in painting which continued through college.

Fraley's paintings have been published in *Erotic Art by Living Artists* (1988) and *American Artists: A Visual Survey of Leading Contemporaries* (1990). He has had several exhibitions of his work at Galerie Simonne Stern and was recently in the invitational exhibits, Spotlight on Georgia Artists and Johnny Detroit's Brunch.

His work has been discussed in *Art Papers* (Jul-Aug 1989), and he is represented by The Lowe Gallery, 75 Bennett St., TULA Complex, A-2, Atlanta, GA 30309. (404)352-8114.

Selected Exhibitions

1990 Spotlight on Georgia Artists Auction for Trinity School (February)
Galerie Simonne Stern, Atlanta Works on Paper Group Show (January)
1989 Galerie Simonne Stern, Atlanta, 2-person show with Mark Jordan Group Show
Artcare Auction, Atlanta
Theatrical Outfit, Atlanta, Recent Paintings
Johnny Detroit's Brunch, Atlanta
1988 Galerie Simonne Stern, Atlanta Group Show: "Art in a Box"
Marietta Theatre in the Square: Recent Paintings
1987 Marietta Theatre in the Square: Figurative Pastel Drawings
1985 Auburn University School of Architecture One-Man Show of Paintings/Drawings
University of North Carolina School of Architecture: Drawings
1984 University of North Carolina School of Architecture· Drawings
1979 Little Five Points, Atlanta, One Man Show
1978 Tulane University School of Art Experimental Transparencies
1975 Presbyterian Medical Center, Lubbock, Texas Commissioned Steel Sculpture for Lobby

A Day at the Capitol

On January 29 and 30, 1990, Auxiliary members assembled at the State Capitol in support of Senate Bill 553: Obstetrical Arbitration Act. Members of the Senate were urged to support passage of this bill and thereby alleviate the OB crisis which threatens thousands of Georgia women seeking prenatal care and delivery services.

Being briefed on Senate Bill 553 by Cynthia Haney, MAG's Assistant General Counsel, are: Seated left to right, Barbara Tippins, Cynthia Haney, Carolyn Moon, Margaret Syribeys. Standing (L to R), Gail Neeld, Cheryl Felder, Ingrid Brunt, Anna Katherine Brown, and Cheri Dennis.

Grace Walden, AMAG President, and Carolyn Moon, Phone Bank Chairman, at State Capitol lobbying for the OB Arbitration Act.

DeKalb County delegation waiting to board Capitol shuttle. Left to right, Margaret Syribeys, Carolyn Moon, and Barbara Tippins.

Doctors' Day Stamp

A STAMP commemorating Doctors' Day? You don't need to lick this one. It's an engraved metal plate that fits into a Pitney Bowes postal machine and imprints the insignia of a carnation and the words "Doctors' Day — March 30th" on letters mailed in the month of March.

This innovative project was introduced at the November, 1989, meeting of the Southern Medical Association Auxiliary in Washington, D.C., by the Auxiliary to the Medical and Chirurgical Faculty of Maryland.

The plate was designed for use by hospitals, medical associations, and medical schools. County auxilians have been encouraged to participate by contacting their local hospitals and medical societies and purchasing the plate at a minimal cost of approximately $25 for presentation to these organizations or having them purchase the plate for their use in March.

Barbara Thibodeaux (Mrs. David) was presented with the first postal plate at the SMA-A Post Convention Meeting last November. Dr. and Mrs. Thibodeaux live in Cobb County, and Dr. Thibodeaux practices at Kennestone Hospital. They have both been active in the medical community for many years. Arrangements were made with the administrator of Kennestone Regional Health Care System to accept and use the plate in March, 1990, in honor of Mrs. Thibodeaux for her many years of service to Cobb County, the Auxiliary to the Medical Association of Georgia, of which she is also a past president, and the Southern Medical Association Auxiliary.

(Reported by Maureen Vandiver.)

Barbara Thibodeaux (2nd from right), Immediate Past President of the Southern Medical Association Auxiliary, is honored with the first Doctors' Day Postal Plate, designed to commemorate Doctors' Day during the month of March. Mrs. Thibodeaux was honored for her extensive service to the community through her many Auxiliary leadership roles. Also shown here (l to r) are Maureen Vandiver (Mrs. Roy) and Barbara Tippins (Mrs. William), both past presidents of the AMAG, and Mr. Bernard L. Brown, President of Kennestone Regional Health Care System.

Whitfield-Murray Medical Society and Auxiliary enjoy an annual picnic each year at Dr. & Mrs. Rodney Ingraham's farm. Games, hay rides, horseback riding, and good food made for an enjoyable Sunday afternoon. Pictured left to right, Male spouse auxiliary member Mark Mahui; President of the Whitfield-Murray Medical Society, Dr. John Antalis; Auxiliary Vice-President, Cathy Antalis; Christina, daughter of Dr. and Mrs. Antalis; and Host, Dr. Rod Ingraham.

MAG Auxiliary Legislative Chairman Cheri Dennis (R) and Mrs. Virginia Tate, wife of Georgia Senator Horace Tate, wait to board the Legi-Express that will take them to Macon with other doctors' and legislators' wives for an afternoon of fun and fellowship.

All Aboard the Legi-Express

TOGETHER, the Medical Association of Georgia and the Auxiliary planned a great day of fellowship and fun for the legislative wives and their "legispecial guests" and auxilians from all over Georgia.

On Tuesday, February 27, we boarded our bus, the "LegiExpress," bound for a tour of historic Macon. Upon arrival, our Macon host auxilians met us at the Hay House for a tour and then on to tour the Cannon Ball House. Next, on to the Sidney Lanier Cottage where Mrs. Mary Olmstead, wife of Senator Tommy Olmstead, had arranged a presentation by the Macon Cherry Blossom Committee. Leo's of Macon served us lunch at the Sidney Lanier home.

The Auxiliary, and especially its Legislative Team, was thrilled to have the opportunity to respond to the request of the legislative spouses in planning this very special day. It afforded us the opportunity to share concerns and friendship. This was indeed an important mission, and it was a huge success.

Special thanks to all the people who made our day perfect. Mrs. Mary Olmstead of Macon planned the day for the legislative spouses and asked the Auxiliary to be involved. Marty Lane and Jan Cowan of the Bibb County Auxiliary aided in all the preparations, and Gail Neeld of the Auxiliary to the Medical Association of Atlanta and her committee prepared refreshments for the bus trip. The Cherry Blossom Committee and the Macon Convention and Visitors' Bureau also contributed to making this a very enjoyable trip.

Reported by Cheri Dennis (Mrs. Donald P.), AMAG Legislative Chairperson.

DeKalb Auxiliary Holiday Sharing Card

EACH DECEMBER, the DeKalb County Auxiliary has been sending holiday greetings to all members of the DeKalb Medical Society via a Holiday Sharing Card "signed" by those members who wish to contribute to a fund which assists various health-related projects in the community.

In lieu of sending their own holiday greeting cards, the Medical Society and Auxiliary members are given the opportunity to contribute $35 each to a fund that goes to the DeKalb County Health Department as well as to other health and medical projects in DeKalb County. Through the Health Department's Vision Screening Program, each school age child's eyes are tested. If the child fails the screening and the family is unable to afford an examination by a physician, funds are provided for both a physician visit as well as eyeglasses if needed. The Neonatal Care Unit at Dekalb Medical Center and Teenage Pregnancy prevention are among the other projects supported.

In the past, an appropriate card was always selected from a catalog. For the last 3 years, the DeKalb Health Department has helped the Auxiliary organize a contest in which eyeglass recipients submit original drawings for the card. The drawings are judged and the winner whose design is chosen is awarded a $50 U.S. Savings Bond. Since featuring the original artwork of the children, participation of those contributing to the fund has significantly increased.

(Reported by Patricia Daly.)

Of Evangelism, Inertia, and Change"

'Mr. Gringrich said that we must abandon our ways of past years and confront our future with new ideas, new solutions advanced with a new and innovative plan for success — to think "outside the square."'

"Medicine, curative and preventive, has indeed no analogy with business. Like the Army, the police, or the social worker, the medical profession is supported for a benign, not a selfish, for a protective, not an exploiting, purpose."

ABRAHAM FLEXNER
Medical Education in the United States and Canada
Carnegie Foundation
For the Advancement
Of teaching. 1910

"I heard them talking to one another in murmurs and whispers. They talked about illness, money, shabby domestic cares. Their talks painted the walls of the dismal prison in which these men had locked themselves up. And suddenly I had a vision of the face of destiny.

"Old bureaucrat, my comrade, it is not you who are to blame. No one ever helped you to escape. You, like a termite, built your peace by blocking up with cement every chink and cranny through which the light might pierce. You rolled yourself up into a ball in your genteel security, in routine, in the stifling conventions of provincial life, raising a modest rampart against the winds and the tides and the stars. You have chosen not to be perturbed by great problems, having trouble enough to forget your own fate as man. You are not the dweller upon an errant planet and do not ask yourself questions to which there are no answers. You are a petty bourgeois of Toulouse. Nobody grasped you by the shoulder while there was still time. Now the clay of which you were shaped has dried and hardened, and naught in you will ever awaken the sleeping musician, the poet, the astronomer that possibly inhabited you in the beginning."

ANTOINE DE SAINT-EXUPERY
Wind, Sand and Stars
(Observations made on a short bus trip with French governmental employees concerning whom he is speaking.)

"Harbors are made safe for mariners not by the records of successful voyages, but by plumbing the depths and charting the reefs which have led to disaster."

ANON

EVERY NOW AND THEN comes to our thinking a stimulus for change. For new directions, a challenge to disturb our peace and unblock the chinks and crannies of our lives to that light might shine in, as Antoine de Saint-Exupery might put it. We heard such in the form of an address at the 1990 Leadership Conference of the MAG last February. It carried a message, in the biblical sense of that term, of

which we all need to be aware. The words and the delivery broke upon us as might have those of a campground revivalist. Indeed, they crackled with the aura of originality, believability, and challenge that lead many to say to this editor that every physician in the state should hear them. That enthusiastic encouragement has led us to arrange to publish the ringing address of U.S. Congressman Newt Gingrich, he the representive of the 6th district of Georgia, in the May, 1990, issue of your *Journal.*

One must be cautious of overzealous proponents of any particular point of view, especially so when such assured disciples of a discipline as politicians or overly committed theologians press us too emotionally to allow calm and rational cognition of the facts. I find that particularly necessary at Every Member Canvass time in our church, or when solicitation for charitable contributions descends upon me. But at least to this listener, the words of Newt Gingrich, followed by a calm consideration of them, advocated a truth we physicians need to heed.

What did he say as best one person heard him? I came from that address with two salient thoughts. First, that what we as physicians are doing in the political arena and the manner in which we are doing them are wrong and are not working. We have lost every political battle in which we as an organization have engaged ourselves in over the past many years and that goes right back to 1965 with Medicare. Perhaps we lost those encounters not because our motives were flawed but rather because somehow the way we presented our views and the tactics we used to promote them in the arena were inaccurately perceived and the illogically presented. The oceans abound with the dashed hopes of ill conceived voyages. One can only reflect with sadness that our travail continues yet, as RBRVS designs our future leaving behind the wreckage of futile efforts.

But then, secondly, came the evangelism. The challenge. Then Mr. Gingrich said that we must abandon our ways of past years and confront our future with *new* ideas, *new* solutions advanced with a *new* and innovative plan for success — to think "outside the square." Abandon the time tested foundations of our profession, our morals, our ethics? No, not that. Keep the good, the tried, and the workable. Abandon those archaic and tired beliefs, convictions, which are no part of our value system and which have served us poorly? Reorganize our national organization so that it is perceptive of our membership and capable of attracting most if not all to its bosom? Perhaps. Define and pursue health care initiatives agreed upon in concert with others with a fidelity demanding respect and belief? Surely. Come to a realization that in the years ahead decisions regarding the care of the sick will not be ours alone to make? Without question.

Panic seized me. The address was over. He strode from the room as a triumphant gladiator leaving us behind — excited, challenged, ecstatic, confused. Alone with our thoughts. Must I now discard those precepts taught me so long ago in that lonely midwestern metropolis by the surgical denizens of that day? Must the Glover Cophers, the Gene Brickers, Evart Grahams of my life be placed upon the shelf of memory no longer to impact the decisions of my future? I think not. A quiet came back to me. He only said, "It is thus that I see you. Thus that the public, your patients, see you. Look closely in the mirror of your past. Learn from your failures. Hold fast to your basic values. Loose hold upon your unproven fixations."

Tomorrow belongs to the perceptive, to the diligent, to the honest, to the innovative. It belongs to all who position themselves in the world of medicine as did those people from our state who died in the tragedy of an airplane crash at Orly Airfield in Paris so many years ago position themselves in the arts. Others built a Symphony Hall in Atlanta to honor them and upon its walls they emblazoned these words,

"To All Who Truly Believe The Arts Are An Effort Of The Human Spirit To Find Meaning in Existence."

And so it is with our lives. With our practice of medicine. We must comport ourselves so that we find meaning in existence.

CRU

APRIL

21-22 — *Augusta:* **Pathology Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

21-25 — *Sea Island:* **Sixth Annual Masters in Gyn/OB.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-26 — *Atlanta:* **Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXIII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-27 — *Atlanta:* **Rehabilitation and Treatment Goals in Gastric Urology and Nephrology.** Contact National Kidney Foundation of Georgia. PH: 404/248-1315 or Dr. Nancy G. Kutner PH: 404/727-5561.

26-28 — *Pine Mountain:* **MAG House of Delegates.** Contact Lynn Pearson, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535.

29-May 2— *Sea Island:* **Georgia Society of Ophthalmology.** Category 1 credit. Contact Ray Williams, GSO, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535.

30-May 5 — *Augusta:* **25th Annual Primary Care and Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

MAY

7-11 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-11 — *Statesboro:* **Sobering Issues of the Decade.** Category 1 credit. Contact Susan E. Pajari, Willingway Hospital, 311 Jones Mill Road, Statesboro 30458. PH: 800/242-4040.

14-18 — *Atlanta:* **Introduction to Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

17-20 — *Helen:* **Georgia Rheumatism Society.** Category 1 credit. Phil Bonner, Arthritis Foundation, Ga. Chapter, 2045 Peachtree Road, Suite 800, Atlanta 30309. PH: 404/351-0454.

18 — *Macon:* **Annual Day of Surgery.** AMA Category 1 credit and AAFP Prescribed credits. Contact Mercer Univ. Sch. of Med., Office of CME, Macon 31208. PH: 912/744-1634.

18-20 — *Hilton Head:* **Georgia Radiological Society and Georgia Society of Nuclear Medicine.** Category 1 credit. Contact Frank O. Underwood, M.D., 1984 Peachtree Rd., NW, Ste. 505, Atlanta 30309.

18-20 — *Pine Mountain:* **Quarterly CME/Residents' Research.** AMA Category 1 credits and AAFP Prescribed credits. Contact Judy Rayburn, Dir. of Education, GAFP, 3760 LaVista Rd., Ste. 100, Tucker 30084. PH: 404/321-7445 or 800/392-3841.

22-25 — *Atlanta:* **First Conference on Visualization in Biomedical Computing.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-25 — *Pine Mountain:* **Annual Perinatal Conference.** Category 1 credit. Contact Glenda Driskell, The Medical Center, 710 Center St., Columbus 31994. PH: 404/571-1692.

31-June 1 — *Atlanta:* **Cardiopulmonary Rehabilitation Update.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

June

18-23 — *Kiawah Island, SC:* **21st Annual Internal Medicine Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

21-24 — *Sea Island:* **Georgia Chapter of the American Academy of Pediatrics.** Category 1 credit. Contact William Mankin, 4059 Land O'Lakes Drive, NE, Atlanta 30342. PH: 404/237-3922.

28-July 1 — *Sea Island:* **Georgia Society of Dermatologists.** Category 1 credit. Contact Dr. Jack L. Lesher, Jr., GSD, Dept. of Dermatology, 1521 Pope Ave., Augusta 30912. PH: 404/721-3291.

Introducing the Cobb County Symposium 25th Silver Anniversary Program

May 11, 1990, Marietta

In its 25th Silver Anniversary program, the Cobb County Symposium will present "The Stages of Life," at 9 a.m. Atlanta Episcopal Bishop Frank K. Allan will give the keynote presentation. Dr. Betty Siegel, President of Kennesaw State College, will address the topic, "Women and the Stages of Life — A Personal View." This will be followed by a panel of other participants discussing such topics as retirement, aging, etc.

The Symposium will be conducted in the new Performing Arts Theater at Kennesaw State College in Marietta. On Friday, May 11, there will be a special dinner session at the Atlanta Northwest Marriott Hotel (on I-75). The evening program's topic is, "The First 25 Years" and will include highlights of the last 25 years by including segments of past Symposia, including music and comments by some past speakers, such as Dr. John Stone, poet and Associate Dean of Emory University School of Medicine; and John Pruitt, anchor person at WQXI, Channel 11, Atlanta. The Rev. Austin Ford, of Emmaeus House, Atlanta, will give a tribute to the late Margaret Mead who appeared in the Symposium in 1972 and 1975. Other past speakers invited to attend are Atlanta Symphony Orchestra's Robert Shaw (1977), and *Foxfire's* Eliot Wiggenton (1977).

Dr. Charles R. Underwood, a Marietta surgeon and editor of this *Journal*, has moderated many Symposium Panels over the years and was one of the original members of the Cobb County Medical Society Committee who originated the Cobb County Symposium in 1968. He will be the Panel Moderator for the upcoming Symposium on May 11.

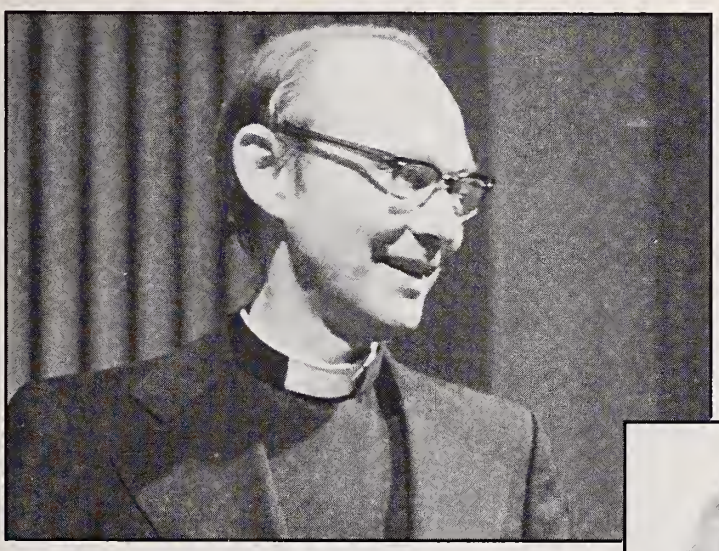
Twenty-five years ago, the American Medical Association established the Physician Medicine & Religion Department and asked each state medical society to establish a similar committee. The stated purpose was to establish better communication between physicians and members of the clergy and as a result, better treatment of the patient as a whole person, taking into consideration all the factors and forces which effects one's health.

The Cobb County Medical Society established such a committee with the help of the Cobb County Medical Auxiliary and with the Kennestone Hospital Chaplains Association. Later, the Cobb County Bar Association joined forces and eventually many other community organizations such as the Cobb/Marietta Jr. League, Kennesaw State College, Cobb Pharmaceuticals Association, Cobb County Dental Society, etc., became full co-sponsors.

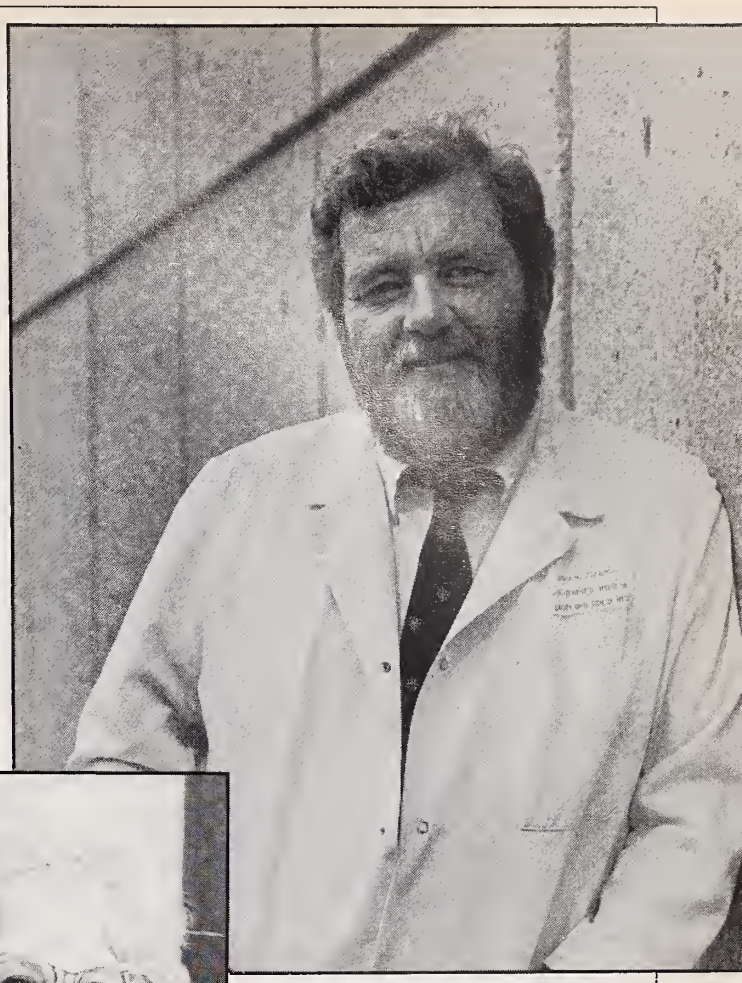
Some of the illustrious 177 speakers at the Symposium have included Margaret Mead, Jonas Salk, Norman Cousins, Elisabeth Kubler-Ross, William Buckley, Charles Kuralt, Art Linkletter, Mrs. Anwar Sadat, Edwin Newman, Richard Leakey, Hugh Downs, and Art Buckwald.

For registration information about the Symposium coming up this May, write Special Events, Kennesaw State College, Marietta, GA 30061 or call 404-423-6252. All events are free of charge except for the Friday night dinner. No preregistration is required.

Featured Speakers At the Symposium

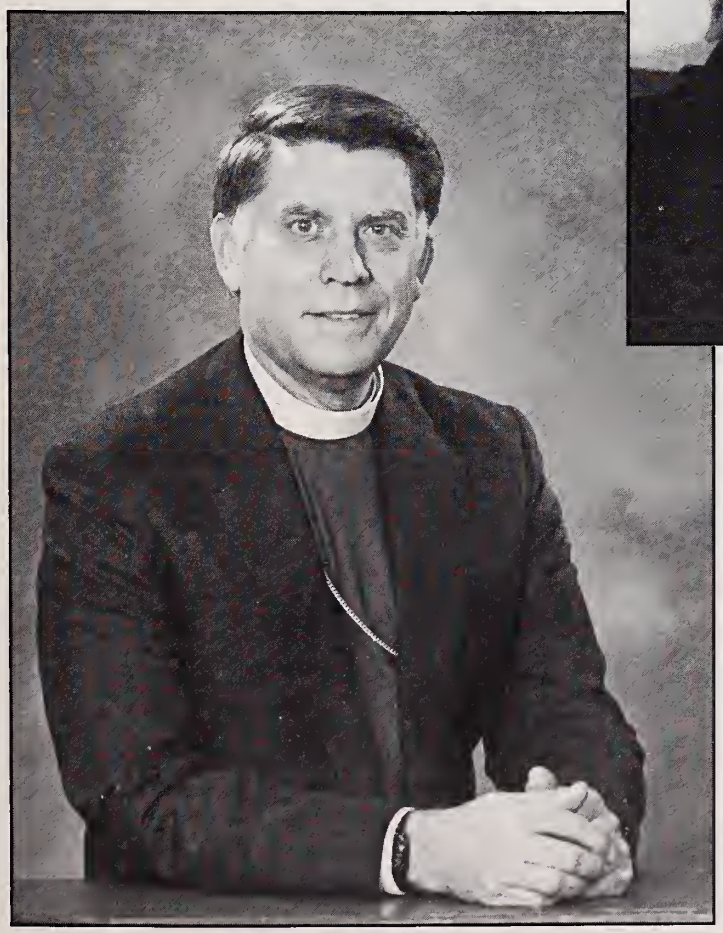


The Reverend Austin Ford, Director, Emmaeus House, Atlanta



John Stone, M.D., poet and Director of Admissions, Emory University School of Medicine

Dr. Betty L. Siegel, President, Kennesaw State College



The Right Reverend Frank K. Allan, Bishop, Episcopal Diocese of Atlanta

John Pruitt, WQXI-Channel Anchorperson

Proud Auxilians Around the State

AMAG President, Grace Walden, Attends County Meetings

Richmond County: *Left to right, Ingrid Brunt, Area Vice-President; Grace Walden, AMAG President; and Paige Bailey tour historic home of the Dean of Medical College of Georgia in Augusta which was the site of the Fall meeting.*

Auxiliary to the Medical Association of Atlanta: *Membership Coffee held at home of Jan Collins in Atlanta on October 24, 1989. Tish Lanier, left, President of AMAA, welcomes AMAG President Grace Walden and AMAG President-Elect Jana Hill (right).*

Thomas Area: *Ruthie Hester (left), Area Vice-President for Thomas Area, and Maryline Smith, President (right), discuss plans for a fundraising project to provide scholarships for students in health-related fields.*

Walker-Catoosa-Dade: *Historian Laura Crawley, second from left, discusses Medical History during the Civil War with auxiliary members at December meeting.*

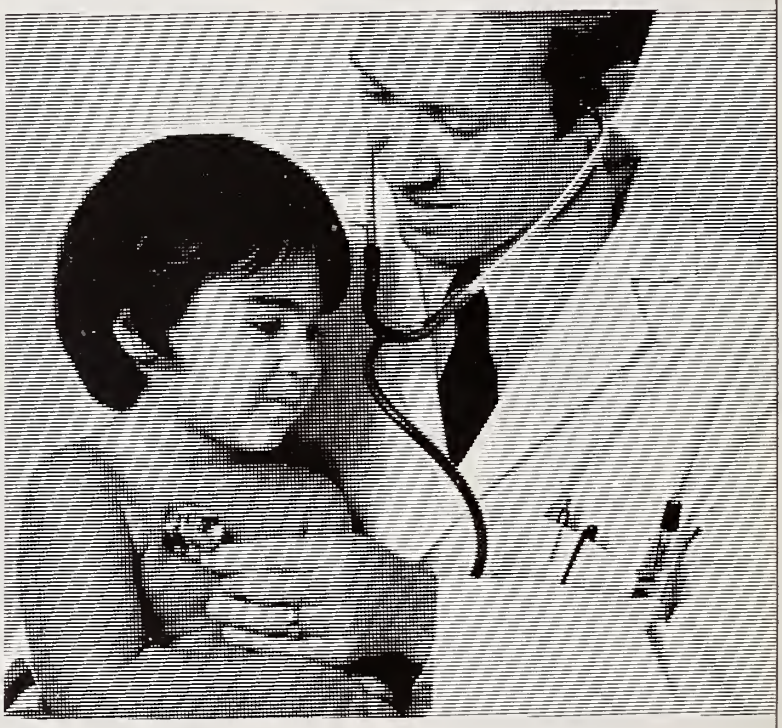
South Georgia: *President Chris Feldman (center) outlines plans for the Teen Health Assessment Program and the marketing of their new auxiliary cookbook,* "Just What The Doctor Ordered" *at the December meeting attended by Grace Walden, AMAG President.*

Tift County: *Patty McLendon (second from left) and Sandy Evans (center) accepting the Southern Medical Association Auxiliary's coveted sweepstake award, the Dr. George D. Feldner Doctors' Day Trophy, for the best overall observance of Doctors' Day of any county auxiliary in the Southern Medical Association.*

Ware County: *A Family Affair: (left and right) Dr. & Mrs. S. William Clark, Jr., he a former MAG President and she (Sue) a former AMAG President; and (center) Dr. & Mrs. S. William Clark, III, attend a joint meeting of the Ware County Auxiliary and Ware County Medical Society. Sue Clark, left, holds a basket of edibles bought at AMA-ERF auction preceding the meeting. Jill Clark is President of Ware County Auxiliary.*

Laurens County: *State President Grace Walden addresses Laurens County about State activities and projects. Pictured (left to right) are Grace Walden, Ruth Ann Price, Betsy Polhill, and Becky Smalley, Laurens County President.*

FAMILY PRACTICE. A REWARDING EXPERIENCE IN ARMY MEDICINE.



The Army has more soldiers with families than ever before. So when you join the Army Medical Team as a Family Practitioner, expect to spend most of your time serving not only soldiers, but their spouses and children, too. What's more, you won't have to worry about the paperwork, malpractice insurance premiums, or the costs incurred in running a private practice.

Expect to work in a highly challenging and varied environment. Working with a team of highly trained professionals, you can receive assignments almost anywhere in the United States; the Army offers the largest system of comprehensive health care in the nation. Family Practice positions are also available overseas, in Germany and Korea.

The benefits package available to Army Family Practitioners is quite attractive. You'll receive 30 days paid vacation, opportunities to continue education and conduct research, a chance to travel, and reasonable work hours.

All in all, your Army Family Practice will be a rewarding experience. Not only for you, but for Army families, too. Talk to your Army Medical Department Counselor for more information.

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ARMY MEDICINE. BE ALL YOU CAN BE.

Village Atlanta — The Gift of a New Beginning

Sandra R. Singer

"IT TOOK ME a long time to understand that people were helping me just because they wanted to help me," a client of Village Atlanta confided to Jane Whaley, a member of the Medical Auxiliary of Atlanta. "At first I thought they had some ulterior motive; I couldn't believe people would just *want* to help me."

A major endeavor of Village Atlanta's dedicated staff is providing the emotional, practical, and spiritual support that enables homeless women and their children to recognize genuine caring. This is the first step toward enabling women to begin the process of redirecting their lives. And the hands-on support of volunteers representing the Medical Auxiliary of Atlanta provides a major link in this chain of new beginnings.

Village Atlanta grew out of a 1984 commitment by Elsie Moses Huck to respond to Atlanta's homeless women and children. With a donation of $25,000 and a dedicated Board of Directors, Huck, then Executive Director of the Atlanta Union Mission Women's Division, founded Ministries to Women-USA, Inc. The first major undertaking of this newly formed Ministry was the establishment of Village Atlanta. After more than 2 years of raising funds, locating property, and obtaining zon-

MAA Auxilian Jane Whaley is one of many Auxilians committed to helping homeless women and children through Village Atlanta. Without saying a word, she tells this wide-eyed child that she is loved and safe.

Ms. Singer is a professional writer in Atlanta. She may be contacted at 404-668-0151.

Photography in this article by D. R. Martin, of Atlanta.

The exterior of this red brick house gives no clue that it is a shelter for homeless women rather than a home sheltering a typical Atlanta family. Village Atlanta's Executive Director Deborah McKone surveys the renovations currently in progress.

A major endeavor of Village Atlanta's dedicated staff is providing the emotional, practical, and spiritual support that enables homeless women and their children to recognize genuine caring.

ing permits, Ministries to Women-USA opened the doors of Village Atlanta to a frightened mother and her small child. The year was 1987.

The exterior of the red brick house gives no clue that it is a shelter for homeless women rather than a home sheltering a typical Atlanta family. Clients are referred by Grady Hospital, temporary shelters, pro-life centers, treatment programs, and Departments of Family & Children's Services. The clients are as young as their early 20s and as old as 42. Women under the age of 18 are not admitted, nor are boys over the age of 13. "The only other criteria for admission," according to Program Director Deborah McKone, "is a commitment to taking time to stabilize their lives."

Some of the women have had little education, others have attended college. They may be in the late stages of pregnancy with their first child, or already have as many as three children. Some of the women have left abusive husbands, others are in a substance abuse recovery program. According to McKone, the only characteristic shared by each of the 40 clients who has walked through the doors of Village Atlanta is the experience of growing up in an abusive home.

When a woman arrives at Village Atlanta, her immediate needs are identified and met. This might include arranging immunizations for one of the children or helping her apply for benefits to which the family is entitled. Now this is where the program becomes unique. McKone encourages the women to take a couple of weeks to "do nothing." This is the first time many of the women have ever been told that it is OK to take a breather and simply recuperate from the high level of stress that has been their constant companion.

Over the next 6 weeks each client either enrolls in school or finds employment. During individual counseling sessions with McKone, she develops and follows a rehabilitation program designed to enable her to achieve a healthier, more independent life style. She attends weekly house meetings, and has the opportunity to participate in Bible study. She establishes a routine of completing chores necessary to run a household, making sure her children eat well-balanced meals, checking their homework, and getting them ready for bed. As she begins to take charge of her life, her self-esteem grows.

"I've seen so many changes in the women who have come through here," says Administrative Assistant Fronita (Chi Chi) Mayberry. "They really learn how to be a parent to their children. They learn how to communicate and they learn to enjoy their children." Mayberry also sees a real transformation in the children whose feelings of anger and resentment are replaced with a newfound trust in their mother's ability to keep them safe.

To support the clients' efforts, Village Atlanta arranges for needed medical care, assists with applications for low-cost housing, offers spiritual support, provides life-skills education, enrolls the children in school, and provides on-site day care. Child Care Worker Amanda Crutcher keeps the infants and toddlers happy and occupied from 7:00 a.m. to 3:00 p.m. After 3:00 p.m., a volunteer or a client not yet working takes over. Knowing her child is safe and well cared for frees a mother to enroll in a training program or find a job.

"Finding affordable housing for clients once they are employed is one of our real challenges," McKone admits. "It is a responsibility shared by clients and staff." McKone's pride in the energy and commitment of her staff is apparent. Mayberry, a trained Master Chef, is housemother as well as administrative assistant. She manages the kitchen, plans the menus, teaches the women to cook, and assigns

Home is where you have your after-school snack. Deborah McKone (center) and Chi Chi Mayberry (right) provide nourishment for both body and spirit. They enjoy the chatter as the children, between mouthfuls, talk about their day. A real transformation is evident in the children whose feelings of anger and resentment are gradually replaced with a trust in this safe environment.

Jane Whaley, Medical Auxiliary of Atlanta, and Deborah McKone, Village Atlanta's Executive Director, exchange ideas on locating housing and jobs for the young women ready to strike out on their own. Whaley and McKone know that a little planning now will have long term benefits for Village Atlanta clients.

chores. And if a client has a problem late at night or during the weekend, McKone knows that one of the other two housemothers, Penny Fowler or Robin Ramsey, will be there to help her handle it.

"Village Atlanta breaks the chain of homelessness and hopelessness," explains Whaley who was recently appointed to their Board of Directors. "And almost 50 members of the Auxiliary, including Board member Martha Korsower, are committed to working hand-in-hand with the staff to help break those chains." This hands-on approach includes raising money, giving pointers on grooming, practicing

"Village Atlanta breaks the chain of homelessness and hopelessness," explains Mrs. Whaley who was recently appointed to their Board of Directors. She and other Board members, auxilians Martha Korsower and Beth Craver, who is also the Board's Chairman, provided the impetus that led to the Auxiliary's long-term commitment to Village Atlanta.

interviewing skills, arranging jobs, and locating curtains for women ready to graduate into their own apartment. Auxiliary member Beth Craver, Chairman of Village Atlanta's Board of Directors, along with Korsower and Whaley, provided the impetus that led to the Auxiliary's long-term commitment to Village Atlanta.

Individuals, churches and corporations contribute money every month to Village Atlanta. Grants from foundations and proceeds from fundraisers are being translated into a new building which will open this summer, expanding Village Atlanta's capacity from 5 to 12 families. Each of the 200 families who can be served every year in the expanded program will have a suite with a bedroom, kitchen, and living room.

For the families who come through Village Atlanta, the help they receive can be symbolized by a stone gently tossed in a pond. These are families who will in some measure owe their futures to the proverbial ripple effect of that stone. Children, who once spent a few brief months at Village Atlanta, will have the chance to grow into adulthood as more emotionally and financially secure men and women who sustain their children and contribute to their community. For these families, the cycle will be broken with this generation.

A Mini Guide for Coping with Illness-induced Financial Adversity

Linda Schwack Harrison, C.P.A.

As PHYSICIANS and physicians families, we are constantly surrounded with illness and death and are therefore fully cognizant of the cycle of life and death. We may have a tendency, however, to hold ourselves above misfortune and to take the blessing of our own good health for granted. Unfortunately, we are no less susceptible to illness, disability, and death than the population as a whole. It therefore behooves medical families to make contingent plans for both their medical practices and their personal lives should illness, disability, or death interrupt their plans.

Whether or not you have taken the time to create a formal financial plan, you have most likely established goals in your mind for such basic things as comfortable lifestyle, educating your children, and enjoying a carefree retirement. You have also estimated what assets will be required to meet your goals. I am asking you now to consider what would happen to your expectations for your future and for your family's future should you incur a probility, or a sudden death. It's not a pleasant thought, is it?

When purchasing disability insurance, you want to be sure that the definition of disability in the policy reads "your own occupation."

Let's consider some actions that you can take now to protect and preserve your medical practice should you become ill at some future time. It is critical to maintain officer overhead insurance and disability insurance. Office overhead insurance pays a set sum to reimburse you for the cost of running your office when you are ill and not longed illness, a permanent disagenerating income. The amount of office overhead insurance you require should be periodically reviewed to keep pace with inflation as well as any significant changes that occur in your office, such as a change of location, an additional location, or an increase in the number of office personnel.

Disability insurance provides you with income to meet the everyday needs of your family. You can self insure with short-term disabilities by selecting a policy which will not pay a benefit until you have been incapacitated for 90 days. This waiting period helps to reduce the cost of the insurance. When purchasing disability insurance, you want to be sure that the definition of disability in the policy reads "your own occupation." This means that if you cannot practice your own specialty, you are considered to be disabled, and the insurance company will compensate you according to the terms of the insurance contract. It does not preclude you from working in nonmedical or unrelated medical field. It is also important that the policy specify that it is non-

Mrs. Harrison is a Manager with the accounting firm of Tauber and Balser, P.C., in Atlanta. She is a past president of the Auxiliary to the Cobb County Medical Society and the Auxiliary to MAG. Her address is 359 E. Paces Ferry Rd., Atlanta, GA 30305.

cancelable which means that the insurance company must renew the policy at a guaranteed premium rate.

The amount of disability insurance you need is usually calculated as a percentage of your income and should be periodically reviewed and updated. Benefits received from a disability insurance policy are income tax free if the insurance premiums have been paid for with personal funds, rather than corporate funds. This will give you approximately 34% more spending power.

Doctors who practice in association with other doctors should have written buy-sell agreements which make provisions for the equitable disposition of all of the assets of the practice, including any real estate that is jointly owned and used by the practice. The agreement will provide compensation for the departing physician or his or her heirs and will establish a predetermined, and possibly prefunded, financial obligation for the ongoing physician and create a harmonious climate for the continuity of practice. The provisions of the buy-sell agreement should consider disability, retirement, and death. If your buy-sell agreement has not been reviewed since the Tax Reform Act of 1986, contact your tax advisor or attorney to review the provisions of the document. There is nothing like a disagreement over finances to turn old friends and associated into quarrelling litigants.

The author discusses some actions that you can take now to protect and preserve your medical practice should you become ill at some future time.

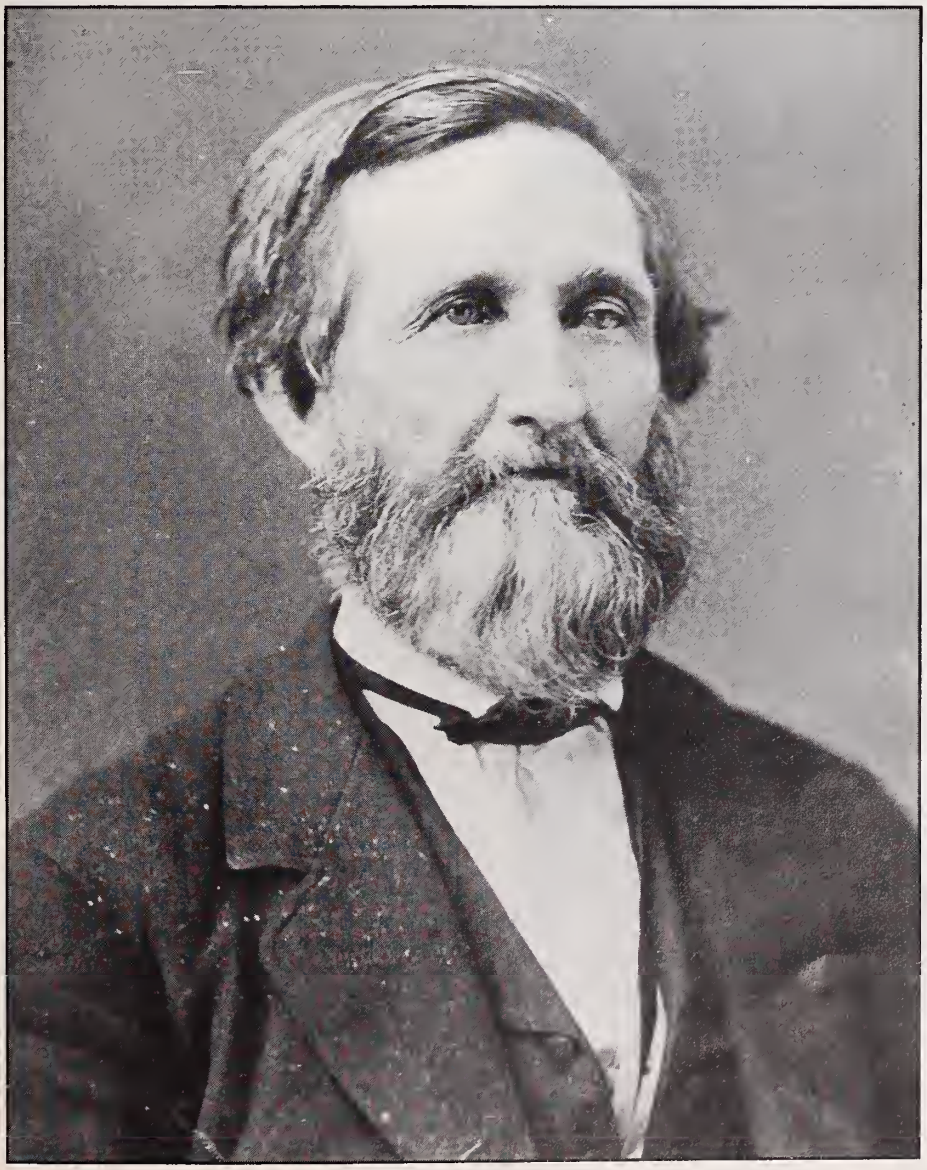
When a solo practitioner becomes incapacitated, the problem is more complex. The initial concern is to arrange for the alternate care of the patients. In the case of permanent disability or death, it may be possible to sell the practice, but you have to act fairly quickly or the practice will dissipate. The practice should be appraised to establish an asking price. Your accountant can assist in accumulating financial information for the scrutiny of the prospective buyer. An aggressive marketing campaign has to be initiated for the sale of the practice, because in many cases you are not only trying to sell a practice but also a community with all of its amenities as the place for the physician and his or her spouse to live and raise their children. Professional help is usually required to search for an acceptable physician, and accountants and attorneys will be needed to draw up the terms for the sale.

It is important for your spouse to be informed about the provisions that you have made should you become incapacitated. He or she should have immediate access to important documents and to the names of attorneys, accountants, and other financial advisors who can help in this difficult time. The Auxiliary to the Medical Association of Georgia has a booklet available entitled, "The Surviving Spouse — How to Cope." This informative booklet provides a broad scope of information regarding the steps that must be taken in the event of the death or illness of a physician. A checklist, "Things the Physician's Family Should Know," is provided to encourage the healthy physicians to accumulate the information his or her family will need in an emergency. The checklist provides space to list financial advisors, the location of important documents, and an inventory of financial assets and insurance information. Completing a second checklist, "What You Need to Know About the Office" will provide your spouse with information he or she will need in order to supervise the clerical activities of your office in an emergency.

No one enjoys contemplating unpleasant circumstances interrupting the normal course of their life. A few moments spent in making important decisions can ease the pain of the situation and dramatically alter the financial consequences should serious illness or death occur. ■

Journey to Jefferson . . . Continued*

Tina James



This 1870 photograph of Crawford W. Long on display at the Museum was used for the 1940 U.S. postage stamp commemorating Dr. Long.

Time flies; good causes stick around.

SOME TIME AGO, the *Journal* reported about an Auxiliary visit to the Crawford W. Long Museum in Jefferson, Georgia. Then — this was 14 years ago, actually — Jan Collins was Immediate Past President of the Auxiliary to the Medical Association of Atlanta, and I was President. Writing in the *Journal*, Jan told how she and I and several other auxilians drove up to Jefferson in a truck carefully packed with an important item for the Museum: Lewis Gregg's famous oil painting of Dr. Long, pioneer in the use of ether as a surgical anesthetic.

That was back in 1976, and many of us remain as dedicated as ever to the cause of preserving Dr. Crawford W. Long's place in history. We are looking forward, for instance, to the Third International Symposium on the History of Anesthesia in Atlanta in 1992, when thousands of physicians worldwide will be paying tribute to Dr. Long, founder of their profession. Another current project is one of petitioning the

*Editor's Note. Jan Collins' article, "Journey to Jefferson," appeared in the December, 1976, issue of the *Journal*.

Tina James (Mrs. W. Scott) is Chairperson of the Auxiliary Committee for the Crawford W. Long Museum. Her address is 510 Heards Ferry Rd., NW, Atlanta, GA 30328.

United States Postal Service to issue a 25 cent commemorative stamp in March, 1992, honoring Dr. Long as the discoverer of surgical anesthesia. (We are mindful that '92 will be the 150th anniversary of Dr. Long's landmark operation in his Jefferson office on March 30, 1842).

Renovated exhibit area of Crawford W. Long Museum in November, 1989, shows a diorama and anesthesia exhibit (partial).

The Crawford W. Long Museum complex as it looks today in Jefferson, Georgia.

Antique Medical Paraphernalia Needed

As I say, time flies but good causes persevere. Just as Jan and I saw to the Crawford Long portrait back in 1976, the Crawford W. Long Museum stands in need again today of other kinds of donations.

A visit to the Long Museum in Jefferson will tell you what I mean. Northeast of Atlanta, about an hour's drive by I-85, there stands in Jefferson the world's tribute to the discoverer of anesthesia. It is an historic, two-story brick structure, built in 1879 on the lot where Dr. Long had his office and where he performed his famous operation. Managed by the Crawford W. Long Museum Association with significant aid from the City of Jefferson (for utilities and staff salaries), the Museum relies solely on donations for all improvements and repairs to our facility. I am proud that the Medical Association of Georgia, together with other groups such as the Georgia Society of Anesthesiologists, has financially contributed so generously to the operation and recent expansion of the Museum facility.

To fill our newly expanded Museum, though, we need the help of medical families throughout Georgia. Already we have on display a number of prized items from our collection: the mortar and pestle actually owned and used by Dr. Long, his eyeglasses, diploma case, even chess pieces. But among the

other exhibits you may see on your visit to the Museum is a specially recreated 1840s doctor's office and drugstore. The Museum Association is dedicated to furnishing this display with authentic medical instruments and furniture one would have seen in a typical northeast Georgia doctor's office 150 years ago.

Hence we issue our call. We know that many MAG auxilians and physicians are collectors of antiques or historical artifacts, ranging from lamps, old stoves, and saddlebags, to medical equipment, apothecary bottles, scales, or old store stock items. If you have any of these or other items from the mid- to late 19th century, which you would like to lend or donate (for tax deductible purposes), we can think of no more worthy recipient than the Long Museum in Jefferson.

The Museum Association is dedicated to furnishing the Long display with authentic medical instruments and furniture one would have seen in northeast Georgia 150 years ago.

Getting There

If you have not been there, the Museum is, of course, a wonderful outing. From Atlanta, take Interstate 85 north to exit 50 (US 129/Ga. 11). Turn right (south), onto 129 heading for Jefferson, about 4 miles away. At the center of town, you'll see the Long Monument erected in 1910 (with help from MAG); a block to the left you'll find the Crawford W. Long Museum, on College Street. Museum visiting hours are Tuesday-Saturday, 10-1 and 2-5; Sunday, 2-5; closed Monday. There is no admission charge, but donations are eagerly welcomed. Phone number in Jefferson: 404/367-5307.

Why not take part in this worthwhile historical undertaking? Time flies but great causes endure. The Crawford W. Long Museum is one of them!

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References:
1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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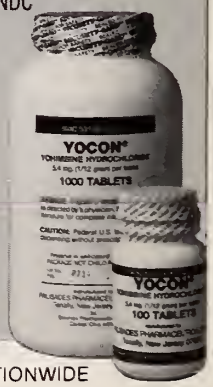

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AMA-ERF — Ensuring Quality Medical Education

Judy Domescik

AMERICAN MEDICAL Association Education and Research Foundation — what does it mean to you? Why is there so much enthusiasm, year after year for AMA-ERF? Why is AMA-ERF the only philanthropic undertaking the Auxiliary has nationwide?

AMA-ERF was established over 35 years ago to help support quality education in the nation's medical schools. Since 1950, the Foundation has distributed more than $49 million in loans benefitting more than 42,000 medical students, interns, and residents supporting numerous research projects. Since the AMA Auxiliary became involved in the fund raising efforts, the AMA-ERF has averaged gifts of over $1 million yearly, with the goal set by the Auxiliary this year for $2.2 million.

But what of AMA-ERF today? How does OUR giving affect YOU, physicians and spouses, the medical community?

In 1989, over $52,000 was donated to the Foundation from Georgia, and the state auxiliary received national recognition from the AMA Auxiliary for significantly increasing its contribution over 1988.

Today there are four funds under the umbrella of the AMA-ERF:

1. *The Medical School Excellence Fund,* which provides grants to medical schools to use as they see fit.

Judy Domescik (Mrs. Gerald) is 1989-90 AMA-EFR State Chairman. Her address is 5725 Riverside Dr., NW, Atlanta, GA 30327.

2. *The Medical School Assistance Fund,* which provides funds to medical schools for student financial aid.

3. *The Development Fund,* used at the discretion of the AMA-ERF Board of Directors to support pilots and experimental health and medical programs.

4. *Categorical Funds* for specific research areas.

As you know, the Auxiliary is directly involved in raising funds for the first two categories.

The Medical School Excellence Fund is the oldest of the funds and the largest. Grants are provided medical schools. Often, these monies are the only unrestricted funds that the dean of the school may use. These deans repeatedly stress their appreciation for the flexibility this money allows in supporting varied activities. They have been remarkable in accounting for the funds received. Following are several quotes from the deans of a few medical

Areas which benefit from the (AMA-EFR) Excellence check are the students' opportunity to hear guest lecturers, the attendance and participation in continuing education courses, presentation of papers at national meetings, and the purchase of equipment and subscriptions to professional and scientific publications.

colleges across the country: "Areas which benefit from the Excellence check are the students' opportunity to hear guest lecturers, the attendance and participation in continuing education courses, presentation of papers at national meetings, and the purchase of equipment and subscriptions to professional and scientific publications." "We have used these funds for a summer student research fellowship program, freshman orientation, minority physician seminar, career decision-making workshop, and costs of the yearly graduation reception." "Giving unrestricted funds allows the dean to initiate new programs, rescue programs of worth, and provide the necessary tools and atmosphere for a quality education."

The Medical Student Assistance Fund requires that the school use the funds to help support bona fide educational expenses for medical students. Again, the deans are quoted: "The monies restricted for student assistance will be used to assist students with temporary, interest-free loans to pull them through critical budgeting problems." "This gift will be added to our existing student loan fund." "We are applying the entire amount to our financial aid/loan program for medical students. This important program is the mainstay of our institutionally based financial aid effort, and we are deeply grateful."

Some schools receive more funds than others. Why? The contributor designates the school to which the money is given. When local societies and auxiliaries enthusiastically support AMA-ERF, there is a significant increase in the donations to schools from that area. It should be noted here that the contributor's donation is tax deductible; so both he/she *and* the school benefit.

The Auxiliary employs several methods of raising funds for AMA-ERF. The most widely-used, totally tax deductible fund raiser is the holiday sharing care. Rather than sending individual holiday greetings, physicians and spouses make a contribution to a "shared" card, with the total monies derived benefitting AMA-ERF. Many auxiliaries send their Sharing Card to their local, state, and federal legislators, to let them know that they are concerned about medicine and medical education.

Giving unrestricted funds allows the dean to initiate new programs, rescue programs of worth, and provide the necessary tools and atmosphere for a quality education.

A special and thoughtful way for medical society and auxiliary members to mark the passing of a colleague, friend or family member is by sending the AMA-ERF "In Memoriam" card, stating that a donation has been made in memory of the deceased. And a unique way

When local societies and auxiliaries enthusiastically support AMA-ERF, there is a significant increase in the donations to schools from that area, since the contributor designates the school to which the money is given.

for medical society members to remember colleagues for professional courtesies and other organizations or people for their support is to send "The Value of Your Service" cards, rather than individual gifts. The entire donation from the sale of these cards goes to benefit AMA-ERF.

A significant amount of funds has been raised for AMA-ERF by the Auxiliary to the Medical Association of Georgia, as well as many of Georgia's local Auxiliaries. In 1989, over $52,000 was donated to the Foundation from the state of Georgia, and the state auxilary received national recognition from the AMA Auxiliary for significantly increasing its contribution over 1988. A few of the many fund raising tactics used by the auxiliaries were auctions, raffles, wine-tasting parties, and, of course, sharing cards.

The goal of AMA-ERF is to ensure the quality of American medicine and medical education. Every time we make a contribution to AMA-ERF we make a statement to the effect that we believe in quality medicine, in continuing to promote the finest health care in this country that the world has ever known. As Ralph Waldo Emerson wrote, "It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself." ■

O.P.A.L.S. — Gems of our Society

Toni Shiver

HOW TO GET BETTER while getting older — that was the focus of a 1-day educational seminar for O.P.A.L.S. (Older People With Active Lifestyles) presented by the Richmond County Medical Auxiliary. Over 350 participants attended this event held last February at the First Baptist Church of Augusta.

The concept for the forum was developed as a result of the success of the statewide teen health forum, "It's Up to Youth," held in Athens, and as a response to our State Auxiliary President's interest in community health programs for older Americans. We decided that this program could be offered to the Central Savannah River Area, which includes 13 surrounding counties in Georgia and South Carolina.

Our auxiliary's goal was to provide a day of "leisure therapy." Through planned workshops offering valuable information, participants explored areas that provided them with the ways and means of aging knowledgeably and gracefully.

Development of the project began shortly after convention. The co-chairperson contacted various county agencies dealing with older people to evaluate community needs and to plan the direction for the forum.

Toni Shiver

In early fall, letters containing information and stating the date of the forum were mailed not only to over 500 churches and synagogues but also to retirement communities and pertinent organizations. A personal invitation was extended to every retired physician and to auxiliary life members. In January, 4000 brochures with registration forms attached were distributed throughout the area.

Toni Shiver (Mrs. Charles B.) is Chairperson of the Auxiliary's O.P.A.L.S. Committee. Her address is 3402 Walton Way, Augusta, GA.30909.

The day's activities began with a welcoming ceremony during which sponsors were acknowledged. Our special guests included Richmond County Medical Society President Dr. Harold Nelson and Augusta Mayor Charles DeVaney, who proclaimed February 15 O.P.A.L.S. Day. Local television personality Bob Smith was our featured speaker.

Eight workshop subjects were offered during the day; these were conducted by experts in their fields. Participants attended four workshops of their choice.

Summaries of the workshops are as follows:

"Myths of Aging — Aging is a Work of Art: Refuting the Myths." This workshop looked at the advantages of being older and becoming the model for the theory that "every age is a good age."

"The Sandwich Generation: The Challenge of Caregiving." The graying of America has given people in their middle years the opportunity to help older family members who are experiencing a loss of independence. At the same time, the job of parenting their own children continues.

"Time for Me — The Possibilities." A. Travel. B. Volunteerism. Opportunities for international travel and volunteerism in the Central Savannah River Area were discussed.

"Uncle Sam Wants You! — You and Your Government." The State Director for U.S. Senator Wyche Fowler, Augusta, taught participants how they could make things happen by becoming active in the legislative process. They also received an update on state and federal legislation which could affect them.

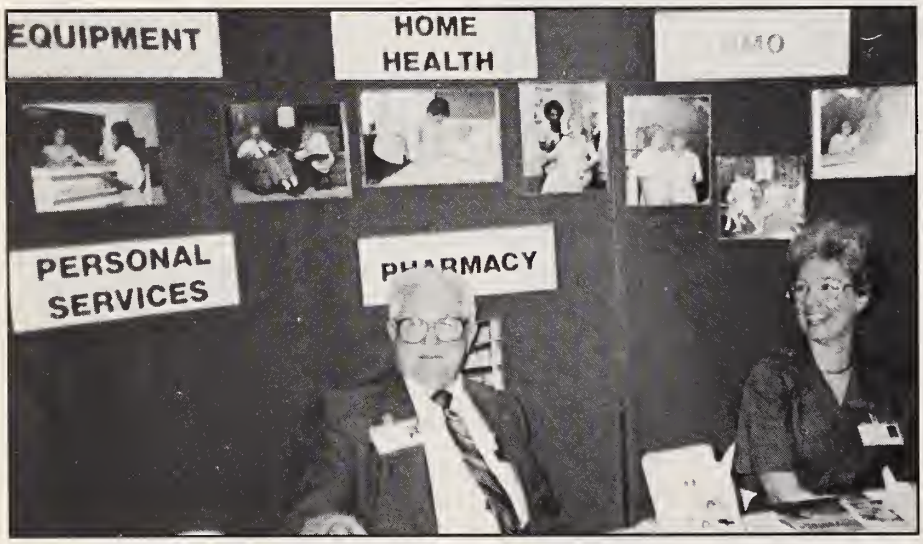
Through planned workshops offering valuable information, participants explored areas that provided them with the ways and means of aging knowledgeably and gracefully.

"Inside and Out — Do You Feel Safe?" This workshop instructed older Americans how to insure their safety when they are out and also how to insure their personal well being in their own homes.

"Looking for a Job?" In the face of nationwide shortages, companies are starting to discover a new, wonderful kind of employee — senior workers.

"Does Anybody Understand Their Health Insurance?" Personal questions concerning insurance coverage, including Medicare, and interpretation of policies were reviewed.

"How to Get Your Ducks in a Row — Financial Planning." Financial planning issues for older Americans, investments, wills, trusts, and powers of attorney were discussed.



There were many exhibits of organizations and businesses at the O.P.A.L.S. Forum. Included were various health care providers and representatives from the Insurance Commissioner, Social Security, and Medicare.

Over 350 participants throughout Richmond County attended the O.P.A.L.S. Forum in which they explored ideas about aging gracefully and knowledgeably.

An exhibit hall provided an area for organizations and businesses related to O.P.A.L.S. to display their services and products. Many of these were directly related to the workshops. Each exhibit had a representative available to answer questions. Included were various health care providers and utility companies. Representatives from the State office of the Insurance Commissioner, Social Security, and Medicare were there to offer assistance.

During a soup and salad luncheon, entertainment was presented by the Augusta Chapter of the Sweet Adelines. Each centerpiece was awarded to the oldest person at the table.

Our goal was to offer materials and interesting concepts to improve the attitudes and lifestyles of O.P.A.L.S. Our ultimate goal, however, was to provide a day of caring, sharing and fellowship, as well as helping older persons enjoy their lives with a sense of pride and dignity. We hope that this forum enlightened the community regarding the importance of this unique segment of society.

Branches of Auxiliary Phone Bank Extend Across Georgia

Carolyn Moon

The Phone Bank is an effective legislative tool for doctors in Georgia, providing concentrated team action.

FACT: LEGISLATORS are more likely to listen to constituents from their home district. Knowing this, MAG has enlisted the Auxiliary to operate a Phone Bank at MAG headquarters to notify physicians across the state of critical issues as they occur during the legislative session. Once the auxilian had made contact with the physician, the physician is to get in touch with his or her legislator.

The Phone Bank program was initiated in 1986 under the leadership of Barbara Tippins, AMAG President, and Jan Collins, AMAG Legislative Chairman. It has worked so well that over the last few years, the Phone Bank has become a "natural partnership" between the MAG and its Auxiliary. MAG's Legislative Team at the Capitol keep the Auxiliary volunteers informed of current and pending medical legislation. The auxilians in turn help to keep the physicians informed through the Phone Bank.

Though it functions primarily during the Georgia Legislative Session, the phone bank can be put into action at any time during the year to contact physicians about critical legislative issues on the state and national level. For example, during the summer of 1989, at the request of AMA, the Phone Bank was activated about a particular national issue. AMA sent a representative to observe the operation, and has since encouraged every state to develop such a system. The Phone Bank operation was featured at the AMA Convention in Chicago in June, 1987. Since then, many improvements have been made, and we expect to continue to improve our methods of operation every year.

During the 1990 Georgia Legislative Session, there were 5 phones available for use at the MAG office on Tuesdays, Wednesdays, and Thursdays from 10:00 AM to 12:00 noon. Prior to making calls each day, Auxiliary volunteers were briefed by the MAG Legislative Staff about the issues of the day, informed of MAG's position and supportive arguments, provided information on the legislators to whom contacts would be addressed, and given a script of pertinent information to aid them in calling physicians. Questions and situations that could arise were also discussed. At the close of each day, Phone Bank leaders recorded a description of what was done and any recommendations for activity the next day.

Carolyn Moon (Mrs. Elliott C.) is the AMAG Phone Bank Coordinator. Her address is 2781 Cravey Forest Lane, NE, Atlanta, GA 30345.

Auxilians Skeeter Burns and Lori Borger from Cobb County phone physicians to let them know to call their legislators about specific legislation being considered at the Capitol.

MAG'S General Counsel, Richard L. Greene and AMAG Executive Director, Talitha Russell (right) advise auxilian Carolyn Moon on contacting physicians about issues before the Georgia Legislature.

Targeted physicians are selected by issue, region, and legislator involved. If a doctor is called, he or she has been targeted for a particular reason.

More auxilians are needed to become involved and work the phones. More physician key contacts are needed to call legislators when medical issues need to be confronted. Legislators *want* to know how doctors wish them to vote on medical bills that come before them. The Phone Bank is operated by Auxiliary members who recognize the value of a doctor's time and would only interrupt an office if directed by MAG to do so. Getting the timely legislative messages through to the targeted physicians has been somewhat of a problem. Targeted physicians are selected by issue, region, and legislator involved. If a doctor is called, he or she has been targeted for a particular reason.

The Auxiliary Phone Bank is an effective legislative tool for doctors in Georgia. It provides a way to unite for concentrated TEAM action in the legislative area, and *Together Everyone Achieves More.* ■

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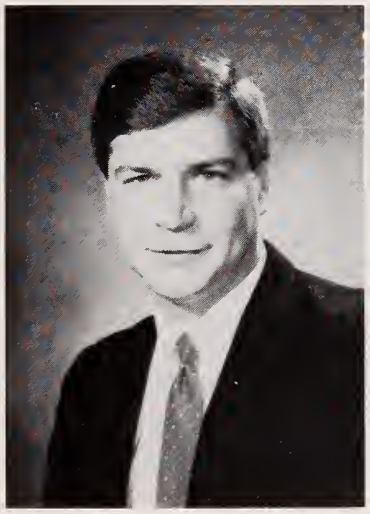

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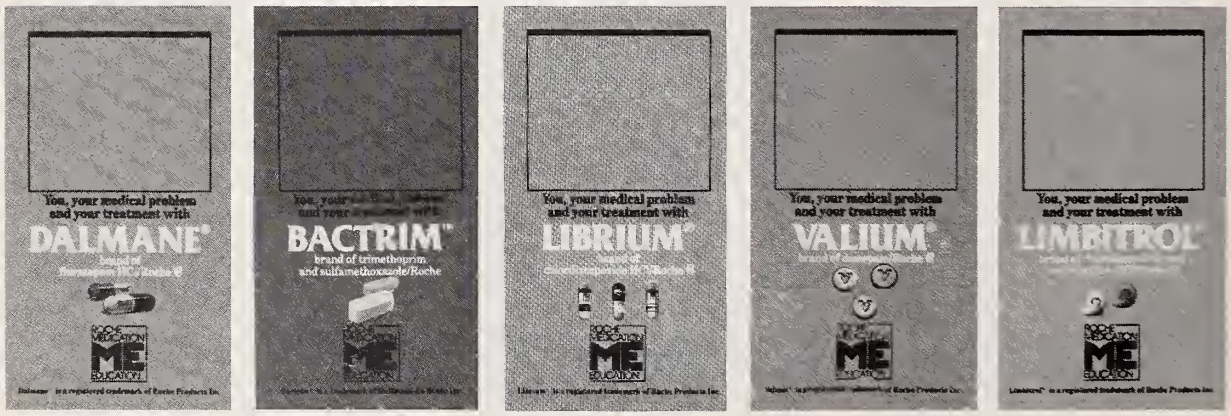

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Unity Within the Auxiliary

Barbara S. Tippins

The AMA Auxiliary made more than 700 calls from Chicago to Washington, D.C., in 3 days with the message, "No ETs." This type of collective action is needed to help the AMA and state medical associations impact both federal and state legislative issues.

THE NEWS in health care today is not always good. More and more we read or hear about a proposal to change the way health care is delivered. Whatever the proposal, however, the effect is the same: physicians are losing the authority to make necessary decisions in patient care but are expected to retain the responsibility for the outcome of that care. Physicians feel disillusioned and often angry; they feel powerless to stop the erosion of their professional autonomy. This is the message auxiliaries are hearing.

In spite of all these infringements on the practice of medicine and the difficulties that plague the medical profession, the AMA Auxiliary believes the medical community has the opportunity to make an impact on what is happening in health care today. We have the opportunity to work together towards the goal in which we all believe — the health and well being of the people of this nation.

Jean Hill (Mrs. Edward) president of the AMA Auxiliary, chose "unity" for her philosophical impetus for the auxiliary this year. Mrs. Hill stated in her inaugural address: "Unity is that oneness of purpose and action that enables people collectively to achieve what no individual can do alone." Unity in the medical community does not mean physicians alone. As partners with the medical profession, we must be united so we can use the power that is within the medical auxiliary in those areas where we have special influence.

Barbara Tippins (Mrs. William C., Jr.) is AMAG Past State President and AMA Auxiliary Southern Region Director. Her address is 1772 Tamworth Ct., Dunwoody, GA 30338.

Legislation

A key area of auxiliary involvement is legislation. Those who attended the AMA Auxiliary Annual Session last June had the opportunity of participating in a campaign to let Congressmen know how the medical community felt about ETs. ETs were not the cute little extraterrestrial beings dreamed up by Spielberg, rather they were more like powerful dragons. Expenditure Targets (ETs) was a device the House Ways and Means Committee developed to control Medicare volume, which in essence would produce rationing of medical care for the elderly. As developed by the committee, a target amount would be set for a given year for physicians' services. If the amount of services delivered exceeded the target amount, physicians as a whole would be penalized. Unlike some systems where

funding would cease for the year, this system would allow for services to be delivered until the end of the year. Expenditures would then be added up to see how much cost exceeded targets. If the target was exceeded, legitimate increases would not be allowed the next year. Needless to say, Expenditure Targets = Rationing.

The AMA Auxiliary delegates and members made more than 700 calls from Chicago to Washington, D.C., in 3 days with the message, "No ETs." This type of collective action is needed to help the AMA and state medical associations impact both federal and state legislative issues. Through the use of phone trees, phone banks, and the key contact program, auxiliary members can help to impact legislative issues.

Community Health

Community health is another area where auxilians have expertise. Programs produced by the auxiliaries not only help improve the health of people, but they educate them on life-style choices, so they are better informed to make intelligent decisions about their lives. Physicians working together with auxilians on these programs show they care for their patients outside of the office setting.

The AMA asked the auxiliaries to help develop programs to improve adolescent health to work with the HIV/AIDS education programs, and to work with the American College of Obstetrics and Gynecology and the American Academy of Family Practice on their Teen Pregnancy Program — The Male Responsibility. The common element in all of these projects is *education.*

AMA-ERF

AMA-ERF (American Medical Association Education and Research Foundation) is the only philanthropic endeavor of the AMA Auxiliary. In 1950, the AMA began the American Medical Education Fund; in 1953, the AMA asked the auxiliary to join in their efforts to raise funds for medical education. Since the auxiliary became involved, an average of $1 million a year has been raised. In 1957, the American Medical Research fund was established (AMRF). These two, AMEF and AMRF, were merged to form AMA-ERF in 1962. Over $47 have been donated to 127 accredited US medical schools to ensure quality education for those who will deliver health care in the future.

AMA-ERF money is distributed through several different funds. The *Medical School Excellence Fund* provides funds to medical schools to use as they see fit — building improvements, faculty salaries, library books, or student loans or grants. The *Medical Student Assistance Fund* provides funds to medical schools to use in direct financial aid to students recognized as being in need by the schools. The *Development Fund* is used at the discretion of the Foundation's Board of Directors to support pilot and experimental health and medical programs. *Categorical Funds* are provided to specific research areas.

Those making donations to AMA-ERF can specify the medical school and the fund to which they would like their donation to be made. They cannot specify donations to a specific medical student.

Membership

In order to reach our goal of quality health care for all, we must gain the active involvement of our peers through membership in the auxiliary. We must make every effort to provide programs and projects which meet the needs of each individual segment of membership — resident physicians' and medical students' spouses; female physicians' spouses; foreign born physicians' spouses; younger and older physicians' spouses alike. This was graphically exemplified at a recent Leadership Confluence in Chicago. A male spouse member told of his auxiliary experiences: the first meeting he attended, he learned his colors; the second meeting, he learned all about makeup; the next meeting he learned about breast augmentation; just as he was ready to give up, they elected him president-elect and sent him for leadership training in Chicago at the Drake Hotel, where, he related, the only men's room near the meeting hall was designated as a ladies room for the duration of the meeting. Greater efforts must be made to plan for everyone. We need to convince all members and prospective members that their help is urgently needed, that working side by side with the medical profession in a unified effort is our best hope for preserving health care as we know it.

National Staff

Working behind the scenes with the AMA Auxiliary is a staff of 14 in Chicago, headed by Hazel J. Lewis, Executive Director. Carrying out directives of the national board and committees, the staff develops printed and audiovisual materials; answers member requests for resources and materials; manages the Project Bank; monitors finances and investments; and handles membership services and procedures. Staff makes the arrangements for two Leadership Confluences (training for county presidents-elect), the Annual Session of the House of Delegates, National Board, and Committee briefings and meetings.

Auxiliary staff members also work with the AMA staff in such areas as AIDS education, adolescent health, and legislative activities, as well as, with staff of other health related organizations.

The Unity Theme

"Perfect Unity," Mrs Hill concluded in her address, "may be impossible for us to achieve. But we can achieve unity in the sense of expressing our opinions, manifesting our strength, and exerting our influence as one. Let us refuse to settle for anything less. Unity will enable us to work side by side with organized medicine to shape the future of health care. Unity will enable us to work with our neighbors to promote healthy living for all Americans. Unity will enable our county, state, and national auxiliaries to work together to achieve our common goal — a nation in which quality health and health care is in the reach of every citizen."

Together, we can make a difference! ■

First Doctors' Day Commemorated

Anne Hubbard

THE TRAFFIC around the courthouse seemed particularly loud that afternoon of August 1, 1989. Coupled with thumping and pounding of construction on the new wing of the old civic building, it wasn't the quiet, laid-back sort of atmosphere one might have expected in a small Georgia town east of Atlanta, 10 miles off the beaten track of I-85.

The ambience was indeed lively, but so were the voices of the auxilians which clearly rose above the street sounds. SMAA President Barbara Thibodeaux, (Mrs. David C.) of Marietta, President-Elect Janet Campbell, and Georgia Councilor Barbara Tippins, (Mrs. William C., Jr.) of Dunwoody, came to unveil a plaque which honors Eudora Brown Almond who, on March 30, 1933, inaugurated Doctors' Day. This date was chosen because it was on March 30, 1842, that a famous Georgia physician, Crawford W. Long, first used ether during a surgical procedure. Their words along with those of SMA President Dr. Roger Mell, in the brief ceremony in front of the courthouse, paid great tribute to Mrs. Almond's idea as well as to the dauntless doctor's wife herself, who so loved and admired the medical profession that she instituted for doctors a day all their own.

Anne Hubbard

Anne Hubbard (Mrs. Hampton) is Medical Heritage Chairman of the North Carolina Medical Society Auxiliary, and editor of the *Tar Heel Tandem*, the official newsletter of that Auxiliary. This account of the Doctors' Day commemoration was originally published in the Fall issue of the *Tar Heel Tandem* and is reprinted there with few changes.

"She was a tough lady," remarked special guest Evelyn Randolph, (Mrs. William T.) who was hostess of the very first Doctors' Day dinner at her home on the outskirts of Winder 56 years ago. "As a child she loved their family physician, and that's when she started putting doctors on a high pedestal. She put them way up there, BUT. . . ." Mrs. Randolph said with a menacing foreboding in her voice "woe be unto the one that fell off that pedestal."

The ceremonies for the dedication of the placque to Mrs. Almond and Doctors' Day started at the recently opened (1988) Chateau Elan, a winery in Braselton, Georgia. The main building is built in the style of a French chateau and is prominently visable as you drive along I-85. The adjacent buildings, where the local grapes are processed, look to be part of the chateau because they are fronted by a huge *tromp l'oeil* mural which blends in and does, indeed, "fool the eye."

In one of the upstairs banquet rooms of the chateau, a luncheon arranged by the Southern Medical Association was served to the hundred or more people who traveled from all over the southern region for the event. Jean Hill, the new president of the AMA Auxiliary and a past-president of SMAA ('84-

A dauntless doctor's wife, Eudora Brown Almond so loved and admired the medical profession that she instituted for doctors a day all their own.

'85), was there. She had traveled from her home in Hollandale, Mississippi.

There were many stars for the occasion — presidents, past-presidents, board members, mayors and commissioners — but certainly the shiniest was Evelyn Randolph, Mrs. William T. Randolph. At 81, she is remarkably youthful. She is slender and erect, and if you had seen her run up the grassy bank to the courthouse, you certainly would have wondered how such a young-acting woman could have been around to host a dinner in 1933.

Mrs. Randolph was not asked to talk above the traffic noises at the courthouse in Winder, although it probably would not have fazed her. She shared her reminiscenses of the first Doctors' Day with the gathering during the luncheon at the Chateau Elan. Everyone was transported back to those seemingly gentler times by her witty and whimsical remarks. "We played musical chairs at that first Doctors' Day dinner. I think at a later one we even played spin-the-bottle!"

She hastened to remind the people that this all took place during the Great Depression and, elegant as the dinner may have seemed to them, every aspect of it was home-grown or home-made by the participants. "I first said we had turkey, but then I got to thinking about it. We may have wished we had turkey, but nobody had turkey in those days in Winder, Georgia."

Some of the doctors' wives asked Mrs. Randolph how it was that at age 25 (which was what she was in 1933) she was chosen to be the hostess among the six doctors' wives present. "My husband volunteered for me, and I was scared to death." Then, with a far away look in her eyes, she said, I was so in love with that man I would have done absolutely anything he asked."

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From Around the State

Health Projects of County Auxiliaries

Sandra Burns

Several counties conducted "It's Up to Youth" forums, modeled after last year's successful state forum sponsored by AMAG and held the University of Georgia.

THE HEALTH PROJECTS Goals for Georgia for the 1989-1990 Auxiliary year have been to provide health education, to promote prevention of disease and illness, to develop programs which recognize and meet the health needs of local communities, and to create a safer and happier environment for all people. Emphasis was placed on the following health projects.

Safety

Auxiliaries across the state have continued to provide educational programs about the importance of the proper use of safety belts and the correct use of child safety seats. In order to help Georgia attain its goal of having 70% of our population using safety belts and child safety seats correctly by 1990. We have not met that goal, but the good news is encouraging. Recent studies are reporting that safety belt use in our state is now running around 40%. That is an approximate 15%-20% increase since Georgia's mandatory safety belt use law went into effect on September 1, 1988.

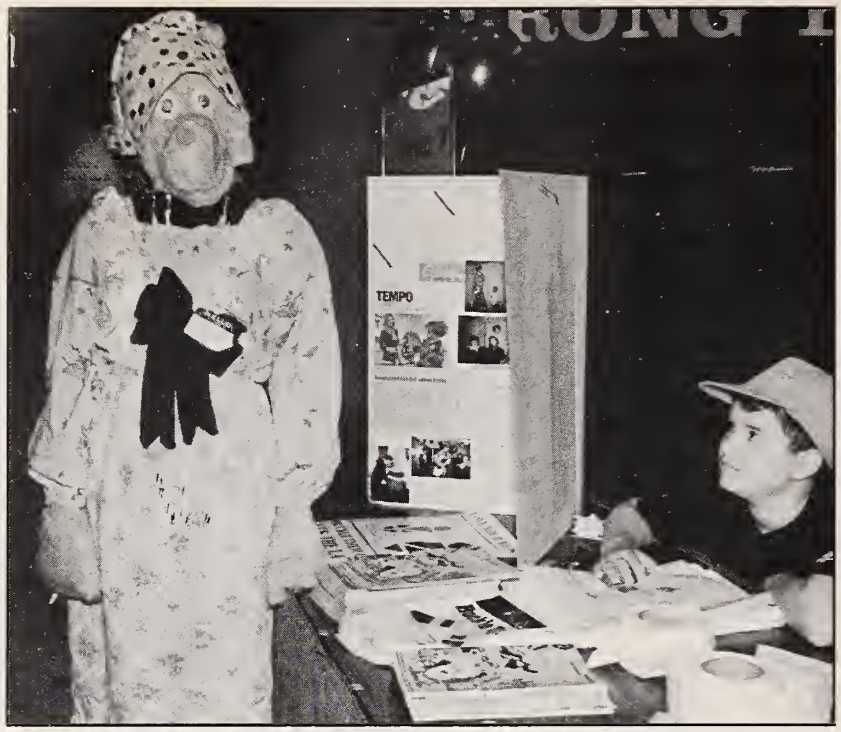
Hall County Auxiliary President, Robbie McCormac, reports that one of the health projects her auxiliary has been involved in this year is a child safety seat program called "Mrs. Bucklebear." This program has been presented to approximately 1,000 preschool children in Gainesville.

According to Ruth Ann Price, Laurens County Health Project Chairman, her auxiliary has developed a seat belt safety program aimed at kindergarten students. This program has been presented to all kindergarten students in Laurens County.

The DeKalb County Auxiliary has started a car safety program whereby auxilians can purchase a car seat to honor a physician.

Members of the Whitfield-Murray County Auxiliary have presented a seat belt safety program to several girl scout troops. They have also been involved in fund raising for the Whitfield County Health Depart-

Sandra Burns (Mrs. Robert A.) is the State Health Projects Chairman of the AMAG. Her address is 1921 Tibbs Terrace, Dalton, GA 30720.



"Mrs. Bucklebear" presented Child Safety Seat program to approximately 1000 Hall County preschool children.

ment to buy additional car safety seats for the loaner program. One of their Doctors' Day Health Projects is to visit each new mother and explain the proper use of the car safety seat. They also give each new mother a t-shirt with the message, "I'm A Born Buckler" printed on the shirt along with pamphlets explaining why children should be buckled in car safety seats. Additionally, auxiliary members work with the hospital to produce a video on infant car seat safety to be shown on the hospital's closed circuit television.

Auxilians were encouraged to join the efforts of the SAFE KIDS CAMPAIGN to combat the number one killer of children — preventable injury. The focus of this campaign is on the five most common types of childhood injuries: motor vehicle trauma, drownings, burns, falls, and choking and poisoning.

The Auxiliary to the DeKalb Medical Society joined the local DeKalb Occupant Safety/Safe Kids Campaign and, represented by Betsy Allen and Linda Gonzales, coordinated the Auxiliary's efforts in such projects as seat belt safety.

Whitfield-Murray Auxiliary members have been involved with the Whitfield County Safe Kids Campaign. This auxiliary donated four bicycle helmets which were given away at a bicycle rodeo. Only one to two per cent of children currently use bicycle helmets. The Whitfield County Safe Kids Coalition hopes to improve this statistic through an educational campaign.

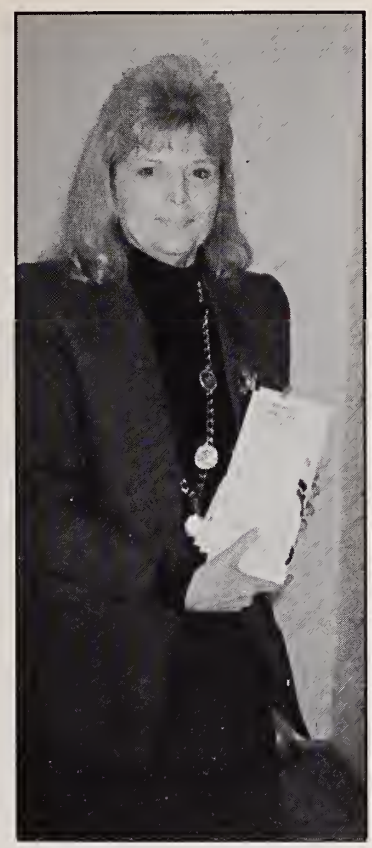
Anti-Smoking

Auxiliaries have been encouraged to continue to educate all communities on the danger of using tobacco products and to work to achieve "A Tobacco Free Society." We know that the largest single preventable cause of death and disability in the United States is the inhaling of tobacco smoke. Over 350,000 deaths occur each year in this country from tobacco use.

Studies show that the number of smokers is decreasing. Fifty-five per cent of all adult Americans smoked cigarettes in 1964. In 1985, less than 30% of adults smoked. Unfortunately, teens and women have been targeted as the new consumers of cigarettes, and their numbers are growing in the use of tobacco.

Many auxiliaries have been involved with efforts to make our hospitals smoke-free and are networking with existing groups to present programs to achieve this goal.

Debbie Brooks, State Health Anti-Smoking Chairman, reports that the Auxiliary to the Richmond County Medical Society and DOC (Doctors Ought To Care) have developed and presented a slide show to all sixth graders in Richmond County for the past several years. This program has been presented at the state auxiliary's board meeting, and several county auxiliaries have presented a similar program in their schools.



Bunkie Rivkin (AMAA) and a team of volunteers canvassed Atlanta OB/GYN offices presenting brochures "Smoking and The Two of You" *explaining the hazards of smoking during pregnancy.*

One area that has captured the interest of auxilians has been smoking during pregnancy. Tish Lanier, President of the Auxiliary to the Medical Association of Atlanta, reports that in January, members of AMAA distributed over 1200 brochures entitled "Smoking and the Two of You," a publication of the American Lung Association. Approximately 50 physician's offices were involved with the distribution of these brochures emphasizing the hazards of smoking during pregnancy.

The Walker-Catoosa-Dade Medical auxiliary worked with the American Lung Association to develop a Smoking and Pregnancy Awareness Program. Once the program was established, a video was made which has been shared with other auxiliaries. Members of this auxiliary have worked with members of the Whitfield-Murray Medical Auxiliary and the American Lung Association to develop a similar program in Whitfield County. Expectant mothers in these counties have received information on the importance of not smoking during pregnancy. It is hoped that they will subsequently maintain a smoke-free life-style.

Many auxiliaries have been involved with efforts to make our hospitals smoke-free and are networking with existing groups to present programs to achieve this goal.

O.P.A.L.S.

This year, county auxiliaries have been encouraged to continue to develop programs that promote healthy life-styles for Older Persons with Active Life-Styles (O.P.A.L.S.). With predictions of increasing numbers of Americans 65 years and older, we must develop programs to help these senior citizens maintain healthy life-styles.

Toni Shiver, O.P.A.L.S. chairman, reports that this is the Richmond County Medical Society Auxiliary's major emphasis for community health this year. Kitty Beveridge, Richmond County Health Projects Chairman, coordinated the development and presentation of a 1-day forum for O.P.A.L.S. Participants were invited for a day of "leisure therapy." They were provided with materials and interesting concepts to improve their life-styles.

This educational seminar reached over 400 citizens in the Richmond County Area. Participants were offered eight workshops. Some of the topics offered were as follows: "Does Anybody Understand Their Health Insurance?," "Inside and Out — Do You Feel Safe?," "Looking for a Job?," and "Myths of Aging — Aging Is a Work of Art: Refuting the Myths." Each session was staffed by an expert in the field.

One of the goals of this forum was for the participants to look at the advantages of being older and to become the model for the theory that "any age is a good age."

Support Liaison Committee

Each county auxiliary was encouraged to develop a support system in each of the following areas: Surviving Spouse, Malpractice Suits, and Addiction.

Many of Georgia's auxilians as well as auxilians from other states have purchased "The Surviving Spouse — How To Cope," from the AMAG. This booklet is a guide to help the family cope with the death of a physician spouse.

The Surviving Spouse Support Chairman, Eldred Smith and Past State President, Dea Porter (both of whom helped develop this guide) have been available this year to speak on this topic at county auxiliary meetings.

The Malpractice Support Chairman, Wilma Tillman, and her practicing physician spouse, Ralph, have traveled across the state speaking on malpractice. Their message to the medical societies and their auxiliaries is about the importance of physicians and their spouses supporting each other during a malpractice crisis.

The Addiction Prevention and Support Committee has been co-chaired by Linda Browne and Connie Menendez. They have offered their assistance in forming support groups for physicians and spouses with addictive problems.

Other Projects

Each county auxiliary has been encouraged to sponsor at least one health project this year. Projects were not limited to the ones that have been previously discussed.

"It's O.K. To Tell," "Someone To Talk To," and other child abuse programs are still being presented throughout the state. Laurens, Hall, Newton-Rockdale, and Whitfield-Murray are a few of the auxiliaries that continue these programs.

In addition, the HIV/AIDS project continues to be implemented in several counties. Laurens County provides AIDS booklets to all ninth

Floyd-Polk-Chattooga Medical Auxiliary: (L to R) Molly Avery, President, and Mary Kirkland, Health Projects Chairman, accepting a check from MAG from AMAG President Grace Walden for the County Teen Health Forum held Feb. 7.

grade students to increase their awareness of the AIDS virus. The Tift County Auxiliary is also involved in AIDS education.

The Peachbelt, South Georgia, Thomas Area, Newton-Rockdale, and Ware County Auxiliaries focus on fund raising to help fund health projects in their counties. They also fund scholarships for health related careers.

Betty Beeson, Health Projects Chairman of the Auxiliary to the Georgia Medical Society, reports that her auxiliary has worked in conjunction with several organizations to institute health programs for schools. Together they have developed a variety of programs and a Lending Library appropriate for different age groups. These programs have been offered to the area schools at no cost. The hope of this group was to expand the school's health curriculum, and to give information to Savannah's youth that would help them make healthy, positive decisions.

According to Debbie Richardson, Health Project Chairman of the Auxiliary to the Dougherty County Medical Society, her auxiliary worked in coalition with several local organizations to produce a documentary on teen pregnancy. This documentary aired on the local television station.

Several county auxiliaries became excited about the success of last year's AMAG state teen health forum, "It's Up To Youth." Plans began immediately after the convention last spring for this to be their main health project for the 1989-90 year.

Since the AMAG decided not to sponsor a state teen health forum this year, MAG decided to distribute their allocated funds among all county auxiliaries planning a teen health forum during 1989-1990. Applications for funds were submitted to an auxiliary health forum committee. The committee, appointed by State Auxiliary President, Grace Walden, reviewed the requests and recommended that each auxiliary planning an "It's Up To Youth" receive an award.

Recipients include the Floyd-Polk-Chattooga Medical Auxiliary for its teen health forum on February 7, 1990. Three hundred 9th and 10th graders from those three counties were invited to the Krannert Center at Berry College in Rome.

The Bibb County Medical Auxiliary received funds for its teen health forum scheduled for March 20, 1990. Four hundred 8th, 9th, and 10th graders were invited from Bibb, Monroe, Jones, and Peachbelt to Macon College for this event.

The Baldwin County Medical Auxiliary was given funds for its teen health forum held at Georgia College on April 5, 1990. Over 500 students from Baldwin, Putnam, and Wilkinson counties were invited to attend.

The Whitfield-Murray County Medical Auxiliary received an award to be used for funding its teen health forum planned for September 18, 1990. Three hundred 7th and 8th graders from the two counties will be invited to participate at the forum to be held at Dalton College.

The South Georgia Medical Auxiliary also received funds to be used in the implementation of a Teen Health Risk Assessment planned for September of 1990.

Richmond County's Auxiliary coordinated the development and presentation of a 1-day educational forum for older persons to help them to look at the advantages of being older and to maintain a healthy life-style.

All of the teen health forums were modeled after the AMAG's "It's Up To Youth." The workbook prepared by AMAG proved to be a valuable resource. Workshops explored adolescent problems: sexual involvement, substance abuse, suicide, safety, and others. Equal time was given to such topics as good grooming, building self-esteem, eating smart, and other "positive addictions." The one long-term goal was encouraging related programs in individual schools.

The evidence is clear. Auxiliaries across the state of Georgia are made up of many caring and committed volunteers, who work hard to support the health projects of their auxiliaries. They are "Proud to be Auxilians." ■

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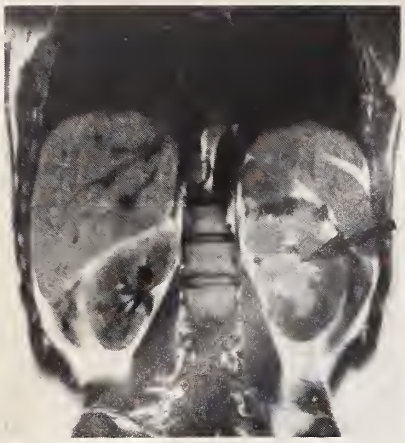

Figure 1

Figure 2

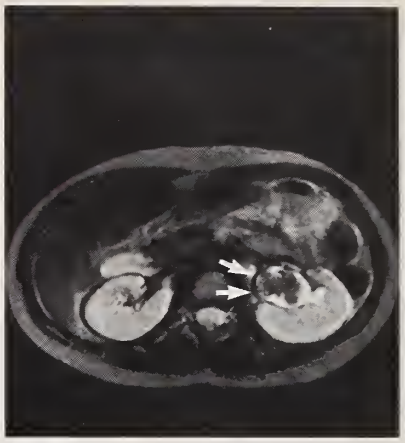

Figure 3

CLINICAL HISTORY: This is a 25-year-old female with complaints of left sided flank pain, nausea, and vomiting.

FINDINGS: Figure 1 represents a coronal T1-weighted image through the kidneys. A lobulated soft tissue mass conforming to the approximate shape of the left renal pelvis and the lower pole collecting system can be identified (large arrow). Signal intensity is intermediate and there is a central area of decreased signal intensity probably representing necrosis. Figure 2 is a sagittal image through the left kidney. In this projection, the soft tissue mass is comma shaped and can be identified extending from the left renal pelvis into the proximal left ureter (small arrows). Figure 3 is a T2-weighted image which exhibits increased signal intensity in the periphery of the mass and central decreased signal intensity. A curvilinear low signal structure lies medial to the mass and is felt to represent the left renal vein displaced by the mass. The vein appears to be patent as evidenced by the low signal intensity indicative of flowing blood (small arrows). No adenopathy is identified. There is no evidence of extension of the mass beyond the margins of the left renal pelvis or the proximal left ureter.

MR IMPRESSION: The location and shape of the soft tissue mass is typical for a transitional cell carcinoma.

MR NOTES: MR of the kidneys is a noninvasive procedure yielding both static and dynamic information about the pathologic process in question. In this case, the MR images defined the presence of the soft tissue mass in the left kidney, the confinement of the soft tissue mass to the left renal collecting system and the proximal left ureter, and the lack of invasion into the kidney and the adjacent pararenal soft tissue structures. In addition, the MR scan demonstrated that there is no evidence of thrombosis of the left renal vein nor is there evidence of tumor into the vein. MR imaging of the kidney is a noninvasive procedure allowing both anatomic identification of renal masses, staging of the extent of those renal masses, and determination of the presence or absence of renal vein involvement for surgical planning.

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Prevention of Sudden Cardiac Death: Lessons from the Cardiac Arrhythmia Suppression Trial (CAST)

Robert C. Schlant, M.D.

"The hypothesis of CAST was that suppression of spontaneous ventricular arrhythmias in patients after myocardial infarction would reduce the rate of death from arrhythmias."

SUDDEN CARDIAC DEATH is a major public health problem in the United States, with perhaps over 500,000 patients dying per year in the United States. In most instances, it is associated with significant coronary artery disease, and most episodes are associated with ventricular tachycardia or ventricular fibrillation. Sudden cardiac death is particularly likely to occur in survivors of myocardial infarction, in whom it has been shown to occur with increasing frequency in patients who have increasing number of premature ventricular complexes (PVCs), complex PVCs, couplets, multiform PVCs, or runs of ventricular tachycardia.

Because of these facts, the National Heart, Lung, and Blood Institute supported a cardiac arrythmia pilot study (CAPS) to determine whether or not it was feasible to identify patients after survival from an acute myocardial infarction who had 10 or more PVCs per hour on an ambulatory 24-hour electrocardiogram or at least five episodes of three consecutive PVCs at a rate of 100 or more per minute. In this initial study, 502 patients were randomized into the following groups: those receiving encainide, flecainide, moricizine, imipramine, or placebo. This preliminary study, with approximately 100 patients in each group, concluded that it was feasible to screen and recruit patients and to treat their arrhythmia with reasonable tient compliance.[1] The adverse effects during therapy with these agents were similar to those seen with placebo and proarrhythmic events were rare.

CAST

Because of the experience with the CAPS, the National Heart, Lung, and Blood Institute initiated a Cardiac Arrhythmia Suppression Trial (CAST). The hypothesis of this second study was that suppression of spontaneous ventricular arrhythmias in patients after myocardial infarction would reduce the rate of death from arrhythmias. To be eligible to participate in CAST, patients have to have sustained a documented myocardial infarction from 6 days to 2 years previously, to have at least six PVCs per hour on an ambulatory 18 to 24-hour electrocardiogram, and to have a reduction in their left ventricular ejection fraction. For patients selected from 6 to 90 days after their infarction, the ejection fraction had to be no greater than 55%, whereas those selected from 91 days to 2 years after the event had to have a left ventricular ejection fraction no greater than 40%.

CAST is designed as a placebo, double-blind, multi-center trial in 23 centers in the United States (including Emory), three in Canada, and one in Sweden. The CAST drug selection committee, after a very careful review of all available drugs, their efficacy in this group of patients and side effects, selected the following three drugs for study in CAST: flecainide, encainide, and moricizine. Flecainide was not given to patients with an ejection fraction less than 30%.

The primary endpoint of CAST is an arrhythmic death, with death occurring less than 1 hour after the onset of new symptoms, resuscitated cardiac arrest, or unwitnessed death without other known non-cardiac causes.

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This Section is sponsored by the Georgia Affiliate of the American Heart Association. We invite original contributions. Send them to our Heart Section Editor, Dr. Schlant, at the above address.

Preliminary Results

At a meeting of the CAST Data Safety and Monitoring Board (DSMB), composed of a group of selected scientists who did not personally participate in the CAST trial, on March 30, 1989, it was noted that a careful review of the first 1,727 patients enrolled indicated that encainide and flecainide showed no benefit and might be harmful. On the other hand, the DSMB recommended that the study should continue with moricizine. As soon as these results became apparent, patients in CAST were taken off flecainide and encainide, and the general medical community was made aware of the results. A preliminary paper has been published describing these early results and the baseline data of the subjects in the CAST study up to that date.[2]

"CAST is designed as a placebo, double-blind, multi-center trial in 23 centers in the United States (including Emory), three in Canada, and one in Sweden."

At present no clear-cut characteristics have been found to identify those patients who are most susceptible to having an adverse effect from flecainide or encainide. Of interest, the increased mortality seen in the patients receiving flecainide or encainide continued throughout the period of the study. This is in contrast to some previous thoughts that a proarrhythmic occurrence would occur very early after the onset of a medication and that the development of an adverse proarrhythmic event would be unlikely after a few weeks.

These results with CAST indicated that mortality from sudden death, cardiac arrest, or total mortality was significantly greater in the patients with potentially significant ventricular arrhythmia after a myocardial infarction assigned to flecainide or encainide instead of placebo. This conclusion was true for many patient subgroups including those with higher or lower ejection fractions, greater or lesser number of PVCs, patients who were or were not on concurrent beta-blockers, and for patients who had their myocardial infarction greater or less than 90 days prior to entering into the study. The majority of the increased death seen in the CAST appeared to be death from cardiac arrhythmia or cardiac arrest.

As a result of this preliminary analysis, it was concluded that flecainide or encainide should not be used to treat asymptomatic or minimally symptomatic ventricular arrhythmias in the 2 years after myocardial infarction. At this time it is not clear whether or not the results of the CAST should be extrapolated to all drugs classified as "IC" or even to all drugs classified in group I. At this time it is also impossible to say that the original hypothesis of CAST, that suppression of PVCs would decrease mortality, is either false or true. The hypothesis may be true for some drugs but not for others. The results of CAST do establish that the proarrhythmic effects of drugs may be concealed and not apparent.

In general, the CAST study is a landmark trial that challenges old concepts about proarrhythmia and that also identifies a risk to patients after infarction receiving flecainide or encainide that was not otherwise clinically apparent.

"The CAST study is a landmark trial that challenges old concepts about proarrhythmia and that also identifies a risk to patients after infarction receiving flecainide or encainide that was not otherwise clinically apparent."

Without such a large double-blind randomized study, it is highly likely that the increased mortality seen with flecainide or encainide would not have been apparent for many years.

New CAST Protocol

At this time, the CAST is continuing with a new protocol because of the importance of trying to determine whether or not suppression of PVCs after infarction will decrease the high mortality seen in such patients. At present, CAST is enrolling patients in a somewhat higher risk group, i.e., patients with an ejection fraction of less than 40% who are less than 90 days after their myocardial infarction. Patients whose ventricular arrhythmia is suppressed by moricizine are randomized to receive either moricizine or placebo. Patients

can be enrolled even though they may have undergone coronary angioplasty or even bypass surgery so long as they have an appropriately reduced ejection fraction and at least six PVCs per hour on an ambulatory ECG.

CAST also emphasizes the dilemma faced by the National Heart, Lung, and Blood Institute and the Food and Drug Administration in appropriately notifying patients and physicians when an adverse response to a drug becomes apparent in a clinical trial. At the time these results of CAST became apparent, it was estimated that from 200,000 to 400,000 patients were on either flecainide or encainide and that many of these patients had recently sustained a myocardial infarction. On the basis of the preliminary data from CAST, it was estimated that there might be an excess of 10 to 20 deaths per week because of such therapy. Accordingly, it was deemed appropriate both to have a public press conference and to send out letters to doctors as soon as possible. While some doctors were disturbed because they did not learn about the results of CAST sooner, it was felt important to try to get appropriate patients to discontinue these medications as soon as possible. Unfortunately, if another clinical trial develops with equally important information that should be distributed to physicians as soon as possible, it may be necessary to use the same means because of the unavoidable delay communicating to physicians through the mail and other currently available communication techniques.

In summary, the Cardiac Arrhythmia Suppression Trial was an extremely valuable, landmark study. It has already produced information of great clinical value as well as causing many new questions to be asked. All of us currently participating in the CAST trial are appropriately proud of what has been accomplished to date and look forward to successfully recruiting patients to participate in the continuation of CAST.

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1. The Cardiac Arrhythmia Pilot Study (CAPS) investigators. Effects of encainide, flecainide, imipramine and moricizine on ventricular arrhythmias during the year after acute myocardial infarction: the CAPS. Am J Cardiol 1988;61:501-9.

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QUOTES

I believe that man will not merely endure; he will prevail . . . because he has a soul, a spirit capable of compassion and sacrifice and endurance.
William Faulkner

To be rich is not the end, but only a change of worries.
Epicurus

I look upon the whole world as my fatherland, and every war has to me the horror of a family feud.
Helen Keller

Things were good once, and they'll be good again; the only trouble with the world is that it's right now.
Jack Webb

He who has no inclination to learn more will be very apt to think that he knows enough.
Thomas Powell

Give to the world the best that you have and the best will come back to you.
Madeline Bridges

To be trusted is a greater compliment than being loved.
George MacDonald

It is a wonderful advantage to a man in every pursuit or avocation, to secure an adviser in a sensible woman. In woman there is at once a subtle delicacy of tact and a plain soundness of judgment which are rarely found to an equal degree in man. A woman, if she be really your friend, will have a sensitive regard for your character, honor, repute. She will seldom counsel you to do a shabby thing, for a woman friend always desires to be proud of you.
The Earl of Lytton

Slow down and enjoy life. It's not only the scenery you miss by going too fast — you also miss the sense of where you're going and why.
Eddie Cantor

Rumba is a dance where the front of you goes along nice and smooth like a Cadillac and the back of you makes like a Jeep.
Bob Hope

The road of excess leads to the palace of wisdom.
William Blake

Touch a thistle timidly, and it pricks you; grasp it boldly, and its spines crumble.
William S. Halsey

There was a time when a fool and his money were soon parted, but now it happens to everybody.
Adlai Stevenson

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Mobile Medical Facilities and CONs: Maneuvering Mobile Medicine Through a Stationary Statutory Scheme

Susan Cowan Atkinson

"By regulating the development of "health care facilities" and "new institutional health services," State health planners sought to insure that medical services were evenly spread among urban and rural areas."

In response to the growing concern over rising health care costs, the unbalanced distribution of health care resources, and the needs of medically underserved rural populations,[1] the Georgia Legislature passed what is now known as the State Health Planning and Development Act in 1978.[2] This Act provides for the creation of the State Health Planning Agency (the "Agency") and, among other things, requires persons proposing to develop certain types of health care services to submit an application to the Agency and obtain a certificate of need ("CON").[3] In this manner, only health care services and facilities "found to be in the public interest shall be provided in this state."[4]

Historically, the idea behind the certificate of need requirement was to provide a geographical balance in the provision of medical services. State health planners sought to avoid an overabundance of medical services in certain areas, a problem which often led to skyrocketing medical costs as half-filled facilities raised rates in order to maintain profits. At the same time, the CON requirement protected less affluent areas which had often experienced a scarcity of even the most basic medical services. By regulating the development of "health care facilities" and "new institutional health services," State health planners sought to insure that medical services were evenly spread among urban and rural areas.

In the 1980s, however, the longstanding model of hospital-based medical services began evolving into a new model which included and even encouraged alternatives to hospital-based care. The provision of medical services changed dramatically as freestanding ambulatory surgical and obstetric centers, "emergicenters," and other nonhospital-based medical services proliferated. The State health planners recognized these changes in the delivery of medical care and incorporated the new services into the certificate of need scheme.

As we enter the 1990s, the landscape of medical services is changing once again as the use of mobile medical facilities gains popularity. As health care providers realize that mobile medical facilities can efficiently provide medical services to wide-ranging geographic areas without the expense of buying equipment in each area, an increasing number of services are being offered in these mobile facilities. Services provided in mobile medical facilities currently range from the fairly uncomplicated, such as blood pressure testing and "wellness" enhancement, to the more complex, such as lithotripsy and cardiac catheterization. Physicians and hospitals are providing these mobile facilities under a wide variety of ownership and leasing arrangements. Currently left unanswered is the question of whether these mobile facilities will require review under the CON regulatory scheme.

General CON Regulatory Scheme

Under the current CON statute and regulations,[5] approval from the Agency must be obtained prior to the development of a "health care facility"; furthermore,

This article was prepared at the request of the *Journal*. Ms. Atkinson is an associate in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Rd., Atlanta, GA 30326. Send reprint requests to Ms. Atkinson.

approval must also be obtained before a "new institutional health service" is offered. A "health care facility" is defined to include:

> *[H]ospitals; other special care facilities, including podiatric facilities and skilled nursing facilities; intermediate care facilities; personal care homes . . . ; ambulatory surgical or obstetrical facilities; health maintenance organizations; home health agencies; and facilities which are devoted to the provision of treatment and rehabilitative care for periods continuing for 24 hours or longer for persons who have traumatic brain injury. . . .*[6]

The definition of "new institutional health service" is rather extensive and includes: i) the construction, development, or other establishment of a *new health care facility;* ii) any capital expenditure *by or on behalf of a health care facility* in excess of the designated capital expenditure threshold (currently approximately $840,000), except expenditures for the acquisition of an existing health care facility not owned or operated by or on behalf of a political subdivision of the state, or by or on behalf of a hospital authority; iii) any increase over a 2-year period in the bed capacity of a *health care facility* beyond 10 beds or 10% of capacity, whichever is less, in a hospital which has maintained an occupancy rate greater than 85 percent during the last year; iv) clinical health services which are offered *in or through a health care facility* which were not offered on a regular basis during the past 2 years; v) any conversion of upgrading of a facility which causes it to become a *health care facility* as defined in the statute; and vi) the purchase or lease *by or on behalf of a health care facility* of diagnostic or therapeutic equipment with a value in excess of the designated threshold (currently approximately $470,000).[7]

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The determination of whether or not a CON is needed commences by analyzing whether or not the proposed medical

service constitutes a "health care facility" under the statutory definition. If the proposed medical service constitutes the development of a new health care facility, then a CON is needed, regardless of whether the facility is proposed to be developed by a hospital, a physician or group of physicians, or otherwise. Furthermore, the determination whether a proposed medical service constitutes a "health care facility" is pertinent in determining whether "new institutional health services" are being offered. As the highlighted areas of the above description of "new institutional health services" illustrate, each of the activities that constitute the provision of "new institutional health services" requires the activity to relate in some manner to a "health care facility." Where "new institutional health services" are offered, a CON is also required.

"In determining whether a mobile medical facility requires a CON, then, one must first ascertain whether the facility constitutes a "health care facility."

Application of CON Criteria to Mobile Medical Services

In determining whether a mobile medical facility requires a CON, then, one must first ascertain whether the facility constitutes a "health care facility." Since mobile medical facilities generally do not operate under a separate license, they should not constitute "health care facilities" which require CONs for development.

However, even if the facility is not a "health care facility," a CON may be required as a result of the ownership of the facility and/or the type of services offered. For example, a hospital may lease the mobile medical facility and provide services itself. Since the definition of "health care facility" clearly encompasses such a hospital lessee, then the lease of the equipment would come within the CON statutory provisions governing the acquisition or lease of capital items "by or on behalf of a health care facility." If the value of the equipment exceeded the statutory threshold (currently approximately $470,000), then the provision of services under such an arrangement would constitute "new institutional health services" and would require a CON. Similarly, the provision of services would be "by or through a health care facility," so if the mobile medical facility offered services which had not been offered regularly through the hospital during the past 2 years, then a CON would be required.

Other types of arrangements, however, might not trigger the CON requirement. For example, physician providers might own the mobile medical facility and provide services in leased hospital parking spaces. In this situation, it would seem that a CON would not be required since none of the activities described under "new institutional health services" would be accomplished by or through a "health care facility." However, questions remain whether this arrangement somehow converts the mobile medical facility into a "health care facility" and whether the actual location of the provision of services (e.g., hospital parking lot versus some location unrelated to the hospital) makes any difference in this determination.

Also left unanswered is the question whether the hospital in this example may have any contact with the mobile medical facility providing services in its parking lot. If the hospital assists in patient scheduling, does this translate into the provision of services "by or on behalf of a health care facility" which requires a CON? Is a CON required if the hospital somehow facilitates the collection of payments from patients? An argument could be made that both of these activities might cause the hospital to become less of a passive observer and more of a participant in the provision of medical services, thus possibly triggering the "by or on behalf of a health care facility" prong of the CON scheme. However, neither the statute nor the regulations provides an analysis of the CON requirement under these or similar circumstances, and providers of mobile medical services currently have no clear guidance as to the applicability of the CON provisions in these situations.

"As mobile medical facilities gain popularity, more questions about their place in the CON scheme will surely arise."

Conclusion

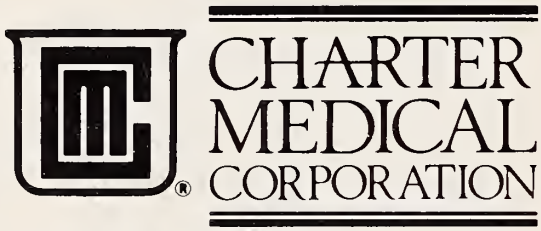
Although the current CON statute and regulations purport to regulate the delivery of health care within the State, they were

not enacted in contemplation of the provision of medical services through mobile medical facilities. The State health planners appear to be approaching this problem on a case-by-case basis, requiring CONs for some types of mobile medical facilities but not for others.[8] As mobile medical facilities gain popularity, more questions about their place in the CON scheme will surely arise.

Until such time as mobile medical facilities are incorporated into the CON scheme, there will remain a great deal of uncertainty as to the extent of the CON requirements when these facilities are utilized.

Notes

1. *See generally* National Health Planning and Resources Development Act of 1974, 42 U.S.C. §300k et seq., repealed by Pub. L. 99-660, Title VII, §701(a), Nov. 14, 1986, 100 Stat. 3799.
2. Ga. L. 1978, p. 941, §4; Ga. L. 1979, p. 1109, §§ 1-3; Ga. L. 1982, p. 3, §31. The current version is found in O.C.G.A. Chapter 31-6.
3. O.C.G.A. §31-6-40.
4. O.C.G.A. §31-6-1.
5. O.C.G.A. Chapter 31-6; Chapter 270-2, Rules and Regulations of the State of Georgia, Official Compilation.
6. O.C.G.A. §31-6-2(8).
7. O.C.G.A. §31-6-2(14).
8. For example, the State health planners do not review mobile lithotripsy units under the CON scheme; however, mobile cardiac catheterization units are reviewed.



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Merkel Cell Tumor: A Review of the Literature

Thomas W. Phillips, M.D., May Abdel-Wahab, M.D.

"In view of the dismal prognosis of this disease along with the potential refraction to ancillary modalities of treatment of metastatic disease, an aggressive approach to the primary treatment should be undertaken."

PRIMARY neuroendocrine carcinoma of the skin (Merkel Cell or Trabecular cell carcinoma) is a rare primary tumor of the skin first described by Toker in 1972.[1] He postulated a possible origin of these neoplasms from elements capable of both sudoriferous (sweating) and neuroendocrine differentiation.[1,2] Further characteristic histochemical and electron microscopic data were later described in these tumors.[3-5] These findings suggested the origin of these tumors to be from the Merkel Cell. They are one of the non-keratinocytic cells in the epidermis, and Merkel neuritic complexes are found in the external root sheath of hairs.[6]

Pathologically, sheets or trabeculae of round cells with a rim of cytoplasm, round vesicular nuclei with multiple small nucleoli, frequent mitoses, and numerous degenerating cells are present.[1-7] Predominantly, lymphatic angio-invasion is very common. Electron microscopy characteristically reveals small dense membrane bound secretory granules, perinuclear intermediate filaments, and complex intercellular junctions.[3-7]

The most frequent primary site is the head and neck.[5,9] The mean age for its occurrence is 65 years.[8,9] Most primary lesions are firm, raised, nodular, red-pink, and non-ulcerated.[7] The natural history of the disease is quite aggressive,[8,9] characterized by a high recurrence rate after surgery alone (45%).[9] This may be due to the fact that the wide excision sufficient to prevent local recurrence may not have been undertaken. Regional lymph node involvement was found in approximately 60% of cases.[5,8,9] Distant metastases were found to occur in approximately 30% of cases.[5,8,9] In view of the dismal prognosis of this disease along with the potential refraction to ancillary modalities of treatment of metastatic disease, an aggressive approach to the primary treatment should be undertaken. Wide surgical excision of the primary lesion with prophylactic regional node irradiation or dissection has been recommended as justifiable treatment in view of the natural history of the disease.[8,9] A dose of 50 Gy tumor dose in 25 fractions over 5 weeks has been recommended.[8] Adequate palliation with chemotherapy can be achieved[2,7,9] according to scarce reports of its use in these

"They are one of the nonkeratinocytic cells in the epidermis, and Merkel neuritic complexes are found in the external root sheath of hairs."

Dr. Phillips is Director of Radiation Oncology, and Dr. Abdel-Wahab is a Fellow in Radiation Oncology, Crawford W. Long Hospital of Emory University, 25 Prescott St., Atlanta, GA 30365.

The Cancer Department is sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute articles should send them to our Cancer Department Editor, Dr. Tom Phillips, at the above address.

tumors. Randomized trials are needed to shed light on the efficacy of systemic therapy and to determine the prognostic factors influencing the outcome of the disease.

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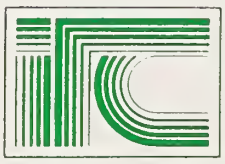

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References

1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

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Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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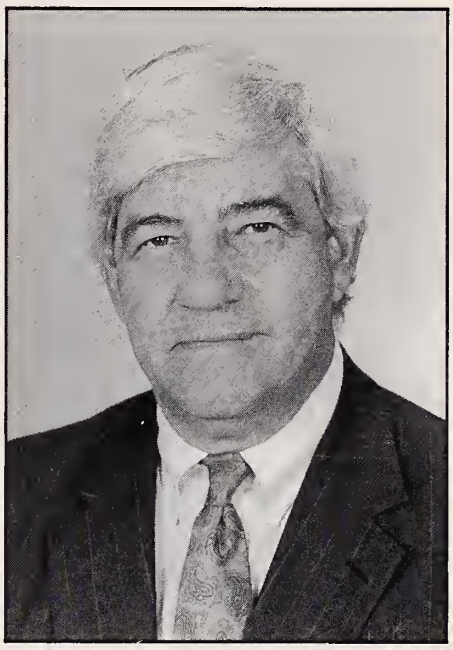

THE TIME HAS COME, the walrus said, to speak of many things. This famous line from Lewis Carroll's, *Through A Looking Glass or Alice In Wonderland* has long been one of my favorites. It is a fitting introduction for the next year of work for the Medical Association of Georgia and for me, as your President. There are many things that we must speak to, speak of, and speak about in the coming year. However, for many of our topics, the time for speaking is over, and we must proceed to action. There are old problems involving third party payors, Medicare reimbursement, the continuing malpractice crisis, and increasing office overhead which must be addressed, not only by ourselves individually as physicians but also by your Medical Association in its constant effort to prove its worth to you — its members.

There are new problems, however, that will demand and get our attention this year, such as improving the image of medicine as a profession in the eyes of Georgia citizens; identifying those of our society who have somehow slipped through the cracks and do not have medical coverage insurance and working with government and business to provide affordable coverage for them; re-establishing our relationships with the other learned professions in the State and seeking to address common problems with them; recruiting young people into the medical care fields; improving the medical care of adolescents in this State by coalition with all parties concerned in areas such as teenage suicide and the medical care and supervision of athletes in contact sports. We will also endeavor to attend to any other problems regarding the health of the citizens of Georgia that can be identified by members of MAG and addressed appropriately.
appropriately.

I dedicate myself to these tasks and hope that many of you will find some areas of interest in this program and will volunteer to join with me along with our Officers, Executive Committee, Board of Directors, and MAG Staff to make this one of the most exciting years ever in the history of the Medical Association of Georgia.

I am excited about this year. I hope you will be, too.

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Roundtree, William E., Family Practice — Muscogee — (Service) L2-A Knight Dr., Columbus 31906

Sauls, David T., Obstetrics/Gynecology — Flint — (Active) 515 East Third Ave., Cordele 31015

Savage-Pedigo, Diane R., Pediatrics — Georgia Medical — (Active N2) 4 Medical Arts Center, Savannah 31499

Scheer, Sallie L. — Bibb — (Student) 980 College St., Macon 31201

Schneider, Diane L., Internal Medicine/Geriatrics — MAA — (Active) 100 Tenth St., NW, Atlanta 30309

Screws, Melinda D. — Bibb — (Student) Rt. 7, Box 195-B, Dublin 31021

Sennett, Michael D. — Bibb — (Student) 855 Mulberry St., Apt. 106, Macon 31201

Smith, Kristin M. — Bibb — (Student) 1923 Adams St., Apt. 1 Macon 31204

Strong, Betty E. — Bibb — (Student) 1975 Vineville Ave., Apt. C-F, Macon 31201

Taylor, Bradley S. — DeKalb — (Student) 1900 Ridgewood Rd., Atlanta 30307

Taylor, Jack — Bibb — (Student) 1821 Adams St., Apt. 5, Macon 31204

Thomas, Pamella D., Occupational Medicine — Cobb — (Active) 86 South Cobb Dr., Marietta 30067

Trippe, Teresa J., Pediatrics — Flint — (Active) 401 Fourth Ave. East, P.O. Box 5133, Cordele 31015

Tyson, Rodney D. — Bibb — (Student) 3876 Northside Dr., Apt. 29-B, Macon 31210

Valdecanas, Mary Anne L. — DeKalb — (Student) Emory University, Box 22340, Atlanta 30322

Vickers, Angela L. — Bibb — (Student) 4501 Sheraton Dr., Apt. 731, Macon 31204

Vowell, Nannette L. — Bibb — (Student) 1946 Forsyth St., #3, Macon 31202

Weiss, Juli S., Anesthesiology — Newton-Rockdale — (Active) 3303 Woodlong Circle, Conyers 30208

West, James H., Internal Medicine — MAA — (Active N2) 960 Johnson Ferry Rd. NE, Ste. 520, Atlanta 30342

Wiggins, Mark W. — Bibb — (Student) 180 Hidden Lake Court, Apt. B-5, Macon 31204

Williamson, Kay S. — Bibb — (Student) 1821 Adams St., #1, Macon 31204

Yoon, Woo-Suk S. — Bibb — (Student) 1975 Vineville Ave., Apt. D-3, Macon 31201

Zora, John A., Allergy — MAA — (Active) 6667 Vernon Woods Dr., Ste. A-30, Atlanta 30328

PERSONALS

Medical Association of Atlanta

Nanetta K. Wenger, M.D., Professor of Medicine (Cardiology) at Emory University School of Medicine, was the Lila Wallis Visiting Professor at Cornell University School of Medicine and the New York Hospital in New York City February 28-March 1. Dr. Wenger was also Visiting Professor at the Brown University Program in Medicine in Providence, Rhode Island, with emphasis in teaching and lecturing for the Brown University Combined Program in Cardiovascular Diseases, March 5-7, 1990.

Douglas County Medical Society

Rajendra Desai, M.D., a cardiologist at HCA Parkway Medical Center on Thornton Road in Atlanta, has been named a Fellow in the American College of Chest Physicians following 9 years on the Parkway staff.

Richmond County Medical Society

Mason P. Thompson, M.D., a native of Greensboro, was recently awarded the Family Medicine Educator of the Year Award by the Georgia Academy of Family Physicians. The award was presented at the annual session in Atlanta. Dr. Thompson was cited by the President of the Academy, Dr. Richard Wherry, for excellence in teaching, academic activity, and patient care.

Dr. Thompson is Vice-President of the Faculty Senate, the faculty organization at the Medical College of Georgia. He authored "Caring For the Elderly," a chapter in the fourth edition of the *Textbook of Family Practice* scheduled for distribution in early 1990 by W.B. Saunders Co. He also serves as the course director of Physical Diagnosis taken by all freshman medical students and was elected by the Class of 1992 to serve as the class faculty advisor.

DEATHS

John Lidelle Chandler Jr., M.D., a retired orthopedic surgeon, from Augusta, died last March.

Dr. Chandler, a native of Rome, had lived in Augusta since 1937 and was a clinical professor emeritus of orthopedic surgery at the Medical College of Georgia. He helped pioneer joint-replacement surgery and was the founder and senior partner of Orthopedic Associates, P.A. He was orthopedic consultant to the former Battey State Hospital in Rome and the Department of Veterans Affairs Medical Center in Augusta, a consultant and clinician to the Georgia Division

of Crippled Children Services, clinical professor of orthopedic surgery at the Medical College of Georgia, a member of the board for the Georgia Department of Human Services, and a past president of the medical staff at University Hospital.

Dr. Chandler received his bachelor's degree in science after studying at Emory University, Atlanta, and the University of Alabama, Tuscaloosa. He received his medical degree from the Medical College of Georgia in 1942. He was called into the Army at the beginning of World War II as a medical officer with the 262nd Medical Battalion, Third Engineer Special Bridgade, and served 3½ years, spending 28 months in New Guinea. He also served in the Philippines and Japan. He was awarded the Victory Medal and the bronze star and the Asiatic Pacific Theater Medal with three bronze stars. He was discharged as a major.

William R. Crowe, Jr., M.D., of Atlanta, a retired internist, died last February of a heart attack. He was 81.

Dr. Crowe specialized in cardiology and allergy and practiced in Atlanta for more than 40 years, retiring in 1976.

A graduate of Emory University and the Emory University School of Medicine, he interned at Grady Memorial Hospital and the Boston Dispensary. He was a Navy lieutenant in World War II.

As a student at Emory, he was a pianist who accompanied the university's glee club, which toured England and sang for the queen. Dr. Crowe studied piano under Earl Chester Smith and Laurie Eberhart in Atlanta. One of his compositions, "Water Hyacinths," was played by Rudolph Serkin at Carnegie Hall in New York. Dr. Crowe was the composer of many popular songs, using the pen name Bill Roland.

Major Frank Fowler, M.D., of Mullins, a retired urologist, formerly of Atlanta, died of a stroke last February. He was 94.

He had practiced in Atlanta for more than 50 years and had served as president of the Fulton County and Georgia medical associations. As the longest continuous practicing urologist in Georgia, he was instrumental in compiling *The History of Urology in Georgia.*

Dr. Fowler graduated from the University of South Carolina and the Medical College of South Carolina. He interned at Roper Hospital in Charleston, S.C., and served briefly with Mullins Hospital before moving to Atlanta.

During World War I, he served with 321st Infantry's Wildcat Division.

Pablo Piedrahita, M.D., a Conyers surgeon, died in February following an extended illness. He was 50.

Dr. Piedrahita had practiced general surgery for 8 years. He was a native of Columbia, South America, where he received his medical degree from the University of Antioquia. He did his surgery residency at St. Mary's Hospital in Waterbury, Connecticut, before coming to Conyers.

Carter Lee Meadows, Sr., M.D., Chief of Surgery at Emanuel County Hospital, died last February. He was 63.

A native of Vidalia, Dr. Meadows had been a member of the staff at Emanuel County Hospital since 1973. He entered the pre-medicine program at Emory University in Atlanta at the age of 15. He received his bachelor of science degree in 1945 from Emory and was a 1948 graduate of Emory University School of Medicine.

Dr. Meadows served with the 64th Field Hospital in Korea, was transferred to the First Calvary Division, and was then promoted to regimental surgeon of the Fifth Calvary Regiment. He was returned to Emory by the Army for additional training and was named Chief Surgical Resident of Emory Hospital. He later became Chief of General Surgery at the army hospital in Fort Dix, N.J. In 1956, he resigned from the Army and began his private practice in Jesup where he was chief of surgery at Jesup-Wayne Country Hospital from 1956 until 1973.

J. Victor Roule Jr., M.D., a retired Augusta ophthalmologist, died last February at the age of 88.

A native of Mansura, LA, Dr. Roule had lived in Augusta since 1971. He was a Fellow of the American College of Surgeons and was Professor Emeritus of Ophthalmology at the Medical College of Georgia.

Charles Stephenson, M.D., a family practitioner in Ringgold, died in February at the age of 84. Dr. Stephenson received his medical degree from the University of Tennessee Medical School in Memphis and interned at John Gaston Memorial Hospital. He played a major role in the establishment of Tri-County Hospital, now known as Hutcheson Medical Center, and served as Catoosa County medical examiner for many years.

Dr. Stephenson was a member of a group of physicians who went to Washington, D.C., after World War II to petition the War

Assets Administration for the Post Hospital and surrounding property at Fort Oglethorpe. The hospital and property were purchased for $1. The physicians signed a note for $100,000 to develop the facility. Dr. Stephenson was a charter trustee of the Hospital Authority of Walker, Dade, and Catoosa Counties which was formed in 1947. Six years later, the authority opened Tri-County Hospital.

Dr. Stephenson was recognized in December of 1989 for his 42 years of continuous service as a trustee when he was elected trustee emeritus by fellow trustees. He was the only charter member of the board still serving and was the first chief of staff of the hospital.

OTHER NEWS

Resident Research Award to be Implemented This Fall

MAG Mutual is currently organizing a Resident Research Award with local county medical societies (CMS) in an effort to encourage resident educational development and membership in local and state medical societies.

MAG Mutual will provide a cash award of $1,000, which will be awarded as each CMS feels is most appropriate. MAG Mutual will also provide a 10-year plaque to be mounted in the hospital or other visible location which will display the winning resident's name. The CMS will be responsible for organizing and promoting the program, as well as for establishing the research criteria and judging panel.

Each residency program is responsible for promoting the award contest to its residents, and the first place winner will have the opportunity to compete with winners from other residency programs in a statewide contest sponsored by the Medical Association of Georgia. Each winning paper will be published in a special issue of the *Journal of the Medical Association of Georgia.* MAG expects to award the statewide winner $250 at the House of Delegates meeting in April, 1991.

The Georgia Medical Society already has its program in place with the awards being presented in May. MAG Mutual hopes the remaining programs will be implemented this fall.

QUOTES

I believe that man will not merely endure; he will prevail . . . because he has a soul, a spirit capable of compassion and sacrifice and endurance.
WILLIAM FAULKNER

To be rich is not the end, but only a change of worries.
EPICURUS

I look upon the whole world as my fatherland, and every war has to me the horror of a family feud.
HELEN KELLER

We are most of us very lonely in this world; you who have any who love you, cling to them and thank God.
WILLIAM MAKEPEACE THACKERAY

Many persons might have attained to wisdom had they not assumed they already possessed it.
SENECA

A real friend is one who walks in when the rest of the world walks out.
WALTER WINCHELL

The heart is the real Fountain of Youth.
MARK TWAIN

Proud-pied April dressed in all his trim Hath put a spirit of youth in everything.
SHAKESPEARE: *Sonnets,* XCVII, 1609

Praise, like gold and diamonds, owes its value to its scarcity.
SAMUEL JOHNSON

There is a pleasure in the pathless woods; there is a rapture in the lonely shore, there is society, where naught intrudes, by the deep sea, and music in its roar.
BYRON

I know that unremitting attention to business is the price of success but I don't know what success is.
CHARLES DUDLER WARNER

Rich men die but banks are immortal.
WENDELL PHILLIPS

A wise man will make tools of what comes to hand.
THOMAS FULLER

Victories that are easy are cheap. Those only are worth having which come as the result of hard fighting.
HENRY WARD BEECHER

The recipe for perpetual ignorance is: Be satisfied with your opinions and content with your knowledge.
ELBERT HUBBARD

The worst handicap is to be unloved, the second worst handicap is to be unloving.
FRANK TYGER

Whence do I get my rules of conduct? I find them in my heart. Whatever I feel to be good is good. Whatever I feel to be evil is evil. Conscience is the best of casuists.
J.-J. ROUSSEAU: *Émile,* X, 1762

LETTERS

Dear Editor,

I read the article by Dwight Lee, Ph.D., in the March, 1990, *Journal of the Medical Association of Georgia,* in which he attempted to present an "economic analysis of the economic burden of cigarette smoking in Georgia." Without question, most people will view this as a verbal tap dance equally insulting as an Al Jolson rendition of "Mammy!"

It is clear that he supports the tobacco industry's public promotion and profit of a product that causes disease and death if used as intended. It is interesting that he cannot correlate the cost of disease and death as a burden that is shouldered by all of society, which it surely is.

As a person who has suffered physically and mentally due to the smoking addiction of others, I also resent his claim that those clods have somehow "paid" for the option to dish out this abuse. They have not "paid" for the stench of smoke they pollute my hair and clothes with. They have not "paid" for the ruined dinners in expensive restaurants. They have not "paid" for smoke and ashes in my eyes on windy days in the bleachers at ball games. They certainly have not "paid" for the bronchial spasms I suffer when smoke is blown in my face and fills my lungs with their expired pollution.

Not all costs to non-smokers are recognized in terms of dollars and cents. Perhaps, if it was possible, even he could understand how ridiculous his article really is.

Sincerely,
Brandon C. Swartwout
Macon

Dear Editor,

This is just a brief note to commend you for the continuing excellence of the *Journal*. It is a very worthwhile publication

One of the things which I particularly enjoy is the inclusion of quotations of various authors from different times and different places. Somehow I suspect you were educated before you were trained as a physician! Years ago, physicians were educated as well as trained in their discipline.

With continuing good wishes,

Sincerely yours,
Arthur G. Singer, M.D.
Radiologist, Toccoa

PHYSICIANS NEEDED

INTERNAL MEDICINE — FAMILY PRACTICE
ONCOLOGY — NEUROLOGY
HEMATOLOGY — ENDOCRINOLOGY

Group practice, solo, or urgent care settings available through our acute care hospital network located in Macon and serving all of middle Georgia.

Your practice will be located 80 miles south of Atlanta in a growing family-oriented community, where you can avoid traffic and enjoy a rewarding professional career.

Please contact Richard Gaston collect at 912/741-6283 for a confidential consultation or write to Richard Gaston, Administrator, Charter Northside Hospital, P.O. Box 4627, Macon, GA 31208.

About the Cover

Alzheimer's and Art

Sheldon B. Cohen, M.D.

A FORLORN, white-haired elderly woman appears to be absorbed in her thoughts. The muted sepia tones seem to indicate that much of the vibrancy of life has been washed out.

The title of the painting "Pariah," labels the woman as an outcast, and the cropped off bottom part of the picture is a potpourri of the woman's rural past (sheep, hogs, owl, and a plow), of her childhood (cartoon characters), innocence and eternity (cherubs in a pool), and her own death not too far in the future (a skull). As the chemical messengers and neurons of the brain lose their capacity to process new information, old circuits which have lain fallow for decades are reactivated with events and memories of the past gaining greater prominence. We can assume that the subject of this picture is sinking deeper and deeper into her past as her body and mind inevitably lose functional capacity.

I can't help but throw out a cautionary caveat in interpreting a portrait. JAMA, like JMAG, features paintings on its covers. For some reason, Portrait of an Elderly Lady, painted in 1633 by Franz Hals, was featured on both the 20 February 1987 and 9 December 1988 covers! Like the portrait itself, the verbal descriptions by Dr. George Ehrlich and M. Therese Southgate are beautiful, artistic, renditions of the painter's life and what they see in the portrait. Regarding her smile, Ehrlich says "Her pink cheeks and slightly bemused expression suggest that she might be impatient to go off to church." Southgate's interpretation is "She is amused at something off to her left — perhaps the antics of a grandchild, perhaps the image of herself dressed in such unaccustomed finery, perhaps even at Hals himself."

Sigmund Freud called the mind "a far country." Observation and interpretation are necessary clinical tools. But — do we really know what the artist thought, much less what the subject was thinking and feeling? If we want to avoid being misled by projections of our thoughts and feelings onto patients, we need to encourage the patient to tell us in his or her own words what is transpiring in that entity we call the mind.

Ms. Bruns is represented by the Fay Gold Gallery, 247 Buckhead Ave., Atlanta 30305; 404-233-3843.

Dr. Cohen practices psychiatry in Atlanta.

Mary Bruns

The Artist Comments

My work has revolved around the individualism and the importance of each personality; primarily, I feel because I was raised in such a small town, Brunsville, Iowa, population about 140. I attended country school, of which one boy and myself made up our grade. The school ran K-6 and from there I was bussed to a larger community of 9,000 or so. It was from the years I spent in that little town, knowing everyone so intimately amidst the tight-knit German-American values, that helped shape this constant of individualism in my work.

I use the realism as a tool of psychologic metaphors for each individual I am describing. Each work is done in split-imagery — one side being a detailed panoramic view, the other a zoom-in, a blow-up of the main character. It is an idea I took from cinematography. Never before in history have things been more vastly and intricately described as on film. It truly defines the speed of the 20th Century.

These intricacies are the interior make-up of each person, the culmination of the years and experiences. I speak of each person as if it is a piece of cinematography; once the detailed panorama is laid out, there is the close-up, that heightens the detail of the moment. They are psychological close-ups in time, of all time being held within each man's psyche and represented by history, forever with that individual.

These are my particular viewpoints using youth and aging, not as a study in geriatrics, but to point out the richness of every age. They are about constant change and imperfection, of individual description and the novelty of the moment. The moment is our time, our his-

tory, ancestors, experiences. Water always appears as the "Fountain of Youth," the symbolic source of rejuvenation and revitalization. It acts as the dichotomy to the whole drama of living. The richness, diversity, and annals that span a human life, the dazzling variety of our respective histories, experiences, and attitudes is echoed in the plasticity of each human mind. I use cartoons, ads, fashion, archives, to give the stamp of "our time." The correlation between youth and aging is where my visual conversation begins.

Pariah is drawn from the day-to-day work concept of many women in the Midwest whose husbands were farmers. Pictorially, everything leans toward that. Diet Coca-Cola drinking putti hover under her skirt while pot and pan yielding putti (the Italian for angels) and gardening tools surround her. The dreams of these women as life began was not one of drudgery, but I'm sure it did share ground with that idea on many occasions. The ideal, of course, is the back-view of the girdled, bra-less feminine wader, which the woman can never become. Pariah wears a man's face — I gave her the core of androgyny because many of these women are just that.

I have lived the past twelve years in Los Angeles, California, before moving to Atlanta in the fall of 1988. I travelled extensively prior to living in L.A. My husband's career as a musician kept us on the move. I have two children, a boy and a girl, 8 and 10 respectively. We all enjoy living in Atlanta very much. There are all of the amenities of a metropolitan area to tap when you need them, but it retains a beautiful liveability that we appreciate.

Group Exhibitions

Los Angeles Printmaking Society
Palos Verdes Art Association
Palos Verdes, CA

Orange County Art Association
Brea, CA

Women's Building
"Cross-Pollination Exhibit"
Los Angeles, CA

Bridge Street Gallery
Los Angeles, CA

Expressions of the Human Figure
Muckenthaler Cultural Center
Fullerton, CA

Images 86
Bowers Museum
Santa Ana, CA

Power Exhibition
Southern California Women's Caucus for Art
Roberts Art Gallery
Santa Monica, CA

Berkeley Art Center Exhibition
Berkeley, CA

Group Exhibition
Clary-Miner Gallery

STROKE RECOVERY

No Longer a Gray Area

Twenty years ago, a gray area of uncertainty clouded the stroke survivor's future. But today the path to stroke recovery is brighter than ever.

For many stroke victims, early, comprehensive rehabilitation is making the difference between self-sufficiency and a life of dependence. In fact, the National Stroke Association recommends a physical rehabilitation hospital as the "preferred next step for most stroke survivors" following the general hospital stay.

And now, with the opening of Walton Rehabilitation Hospital in Augusta, Georgia, the next step is more accessible than ever before. Our multidisciplinary team will help return your patient to an independent lifestyle.

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ACADEMY OF MEDICINE

Down the corridors of time
Men have walked—and still do walk,
Nourishing a dream—

For the engineer, it is a dam, a tunnel, a bridge,—
Or electrical circuits;
For the architect, a building, be it church, or school, or home;
For the physician, a lesson learned, a knowledge shared, a cure;
For the lawyer, the ultimate justice, the balanced scale;
For the banker, the loan secured!

For all, the measure of achievement is the dream,
That even the dreamer's dust does not consume—
To house an art, a science, a hope, a legacy,
The architect must dream, conceive, and see it stand;
The engineer must figure his watts and ohms;
The banker, his interest rate.—

For the lawyer, it has been a podium to share;
For the physician, a giving, a sharing, a school, and a sort
Of a hospital,
For the auxiliary, almost a home!
More than mortar and stone
A monument to man's desire to help his fellow man—
And so the dream started then—
And still the dream is now!

JOHN RANSOM LEWIS

THE MARSHES

(To Sidney Lanier, Ecologist Before His Time)

He who stood beneath the rugged oak
And viewed the tides' great rhythmic surge and sigh
Knew the pulse that fills the marsh's veins
Stays strong to live—or else like man's must die.

The rhythm of man and marsh, with pulse the same,
Continues the vital reverse of ebb and flow—
And just as myriad sanguinous rivulets lie
Like channels so hidden that only marsh creatures know,

This marsh, a tissue of the body earth,
Feel the pulse's change each season and clime—
Life lies beneath, beyond, and because of this pulse,
And man and marsh are granted a gift of time!

JOHN RANSOM LEWIS

Mr. Lewis is Georgia's Poet Laureate.

CALENDAR

JUNE

18-23 — *Kiawah Island, SC:* **21st Annual Internal Medicine Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

21-24 — *Sea Island:* **Georgia Chapter of the American Academy of Pediatrics.** Category 1 credit. Contact William Mankin, 4059 Land O'Lakes Dr., NE, Atlanta 30342. PH: 404/237-3922.

28-July 1 — *Sea Island:* **Georgia Society of Dermatologists.** Category 1 credit. Contact Dr. Jack L. Lesher, Jr., GSD, Dept. of Dermatology, 1521 Pope Ave., Augusta 30912. PH: 404/721-3291.

JULY

9-11 — *Kiawah Island, SC:* **10th Annual Clinical Obstetrics.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

12-14 — *Kiawah Island, SC:* **Update in Gynecology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

16-20 — *Kiawah Island, SC:* **12th Annual Critical Care Medicine.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

23-25 — *Kiawah Island, SC:* **13th Annual Pediatric Update.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

27-29 — *Hilton Head Island, SC:* **Current Financial Strategies — Your Practice and Investments.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

AUGUST

2-5 — *Hilton Head:* **Georgia Psychiatric Physicians Association.** Category 1 credit. Contact Jim Moffett, GPPA, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535.

24-26 — *Sea Island:* **Georgia Society of Anesthesiologists.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

SEPTEMBER

6-9 — *Ponte Vedra:* **Georgia Thoracic Society** (Tri-State with South Carolina and Florida). Contact Dan Groves, American Lung Association, 2452 Spring Street, Smyrna 30080. PH: 404/434-5864.

13-15 — *Hilton Head Island, SC:* **12th Annual Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

16-18 — *Sea Island:* **Georgia Urological Association.** Contact Dr. T. S. Trulock, Albany Urology, 1950 Palmyra Road, Albany 31701. PH: 912/883-1503.

20-22 — *Sea Island:* **Georgia Surgical Society.** Category 1 credit. Contact William McGarity, M.D., Emory Clinic, 1365 Clifton Rd., Atlanta 30322. PH: 404/321-0111.

21-23 — *Pine Mountain:* **Georgia Chapter, American College of Physicians.** Contact Dr. Robert Copeland, 1550 Doctors Dr., Ste. 301, LaGrange 30240. PH: 404/884-2641.

23-27 — *Sea Island:* **Georgia Obstetrical & Gynecological Society.** Category 1 credit. Contact Chester Lane, 69 Butler Street, SE Atlanta 30303. PH: 404/659-0289.

26-28 — *Savannah:* **14th Annual Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

OCTOBER

11-14 — *Sea Island:* **Georgia Society of Orthopaedics.** Category 1 credit. Contact Nell Hurt, 105 Collier Rd., Ste. 5000, Atlanta 30309. PH: 404/355-0743.

12-14 — *Atlanta:* **Gastroenterology for Primary Physicians.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

28-1 Nov. — *Atlanta:* **American Academy of Ophthalmology.** Category 1 credit. Contact AAO, 655 Beach Street, Box 7424, San Francisco, CA 94120-7424. PH: 415/561-8500.

NOVEMBER

2-4 — *Atlanta:* **Georgia Chapter of the American Academy of Pediatrics.** Category 1 credit. Contact William Mankin, 4059 Land O'Lakes Dr., NE, Atlanta 30342. PH: 404/237-3922.

8-10 — *Atlanta:* **Georgia Academy of Family Physicians.** AMA Category 1 credits and AAFP Prescribed credits. Contact Judy Rayburn, Dir. of Education, GAFP, 3760 LaVista Rd., Ste. 100, Tucker 30084. PH: 404/321-7445 or 800/392-3841.

16-18 — *Atlanta:* **MAG Scientific Assembly.** Category 1 credit. Contact MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

Georgia Hospitals Seeing Sicker Patients

A growing number of Georgians today are waiting until their medical condition is life threatening to seek care, according to the Georgia Hospital Association.

GHA reported that 18% of Georgians lack adequate insurance, and 24% (close to one million Georgians) have no health insurance at all.

"Approximately one-third of hospital patients today do not have the resources to pay for health care treatment," said GHA President Joseph Parker, "During the latter part of the 1980s, Georgia hospitals' write-offs for uninsured, indigent, and government-funded patients soared to more than $2.7 million daily, totaling $1 billion annually."

Some relief for both indigent patients and hospitals has come in the form of an indigent care trust fund bill recently signed into law by Gov. Joe Frank Harris. The bill allows hospitals and counties to make voluntary contributions to a trust fund administered by the state Department of Medical Assistance. The Medicaid program, under current law, would be required to match each dollar contributed to the trust fund with two federal dollars. The monies then would be used to offset the cost of caring for uninsured patients in Georgia's disproportionate share hospitals.

In 1987, Georgia hospitals' cost for indigent care, bad debt, and charity totalled $509.5 million. However, hospitals received compensation for only $148 million. Because of these shortfalls, approximately 40% of hospitals in the state will fail to show a profit for 1989, GHA predicts.

Competitive Bidding Needed to Curb Medicare Outlays For Lab Tests

Medicare pays nearly twice as much for clinical laboratory tests as do physicians, according to a recent report from HHS's Office of the Inspector General (OIG).

The discrepancy in rates results, in part, because physicians receive a lower rate for a group of tests, the report said. Medicare Part B pays for the same tests individually, which is more costly. Laboratory representatives maintain that Medicare's complicated billing system also contributes to the extra cost, the OIG said.

The report recommended that the Health Care Financing Administration (HCFA):

- Seek legislation to close the gap in the rate discrepancy;
- Develop procedures and policies for group test rates under Medicare; and,
- Streamline Medicare claims processing.

HHS's FY 1991 budget to Congress calls for "serious consideration" of competitive bidding for clinical laboratory services and for further reductions in Medicare payments to clinical labs.

Medical Technology Tops Growth Industries List

The U.S. Department of Commerce reports that sales of surgical and medical instruments are projected to grow by 10% making the surgical/medical instrument industry the leader among all U.S. industries. The value of surgical and medical instruments should total $10.2 billion this year.

The second-leading growth industry is expected to be surgical applicances and supplies, including such items as wheelchairs, hearing aids, and protective clothing. Shipments of surgical equipment and supplies will increase 9% to an estimated $11.6 billion this year, according to the report.

Based on the Department of Commerce statistics, the combined U.S. market for medical and dental equipment and supplies is projected to total $27.8 billion in 1990. Growth for the medical technology industry will be fueled by the aging population, by the treatment of such diseases as AIDS and cancer, and by an expanding export market for disposable products.

Balloon Angioplasty Not Always Profitable

Although cardiac services have a reputation for being profitable, nearly one-half of 476 hospitals nationwide that offered balloon angioplasty services in 1987 lost money doing the procedure, new study data indicate.

The study, conducted by the Washington, D.C.-based Medical Technology and Practice Patterns Institute, found that 51% of the hospitals experienced an average positive margin of $2,102 per discharge, and 49% of them lost an average of $2,231 per discharge.

The hospitals that were financial "winners" tended to have higher patient volumes, better outcomes, shorter lengths of stay, and many were teaching facilities. With lower patient volumes and higher mortality rates, the hospitals that lost money found that the procedure was financially more expensive to offer.

Plans Boosts Pay For Hospitals With Many AIDS Patients

Under legislation recently introduced by Rep. Henry A. Waxman (D-Calif.), hospitals that serve the majority of the nation's AIDS patients would receive 25% higher Medicaid payments than those received by other hospitals.

Waxman's proposal would affect approximately 50 hospitals that meet certain criteria, including:

- Qualifying as a disproportionate share hospital under their states' Medicaid plans;
- Showing a "reasonable effort" to use outpatient services to reduce hospitalization of AIDS patients; and,
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On Planning

"Americans desire access to high quality health care services at affordable prices and a health care system that is easy to understand and use. The American health care system is now under review by a number of groups. These reviews are being undertaken primarily because many Americans lack health insurance coverage. The increasing cost of health insurance for many Americans who have coverage, particularly the increasing costs within the Medicare program and employment-related coverage, is of increasing concern. The physicians of America, who are represented through the American Medical Association, believe that improvements need to be made promptly to our health care system, especially addressing cost issues and the lack of insurance coverage. Thus, the AMA has developed a proposal to ensure access to the benefits of the American health care system for every citizen. The diversity of those without insurance necessitates a broad-based approach, utilizing both the public and private sectors, to fashion solutions. Many difficult decisions regarding the allocation of society's resources will need to be made to accomplish the goal of extending access to everyone. The AMA believes that a national dialogue must take place to address these challenges and critical issues. The problems facing the American health care system cannot be solved by any one organization. A collaborative process should be pursued, working with government and others."

Health Access America
— The AMA proposal to improve access to affordable, quality health care

"In 1989, the AHA Board of Trustees identified the absence of consensus on a national health care strategy as a major source of growing dissatisfaction with existing delivery and financing arrangements among policymakers, patients or consumers, and providers. Today, this dissatisfaction is expressed in numerous commissions examining problems with the existing system or presenting recommendations for system-wide reform. The AHA Board of Trustees believes it is essential for hospitals to participate actively in the public debate over health care reform, rather than responding to proposals developed by others. The AHA national health strategy project was undertaken to allow the nation's hospitals to play a leadership role in health care reform. The purpose of the AHA national health strategy project is to establish a clear direction or goal for health care reform. The Board approaches this task starting from the assumption that reform should build on the strengths of the pluralistic health care delivery and financing system that has evolved over the past 50 years, but recognizing that profound change in those arrangements may prove necessary. The end product of the AHA national health strategy project could be characterized as a "vision" of the health care delivery and financing arrangements that will take us from the end of this century and serve as the foundation for health care in the next."

The American Hospital Association
National Health Strategy Project

"To be sure, the Enemy wants men to think of the Future too — just so much as is necessary for now planning the acts of justice or charity which will probably be their duty tomorrow. The duty of planning the morrow's work is today's duty; though its material is borrowed from the future, the duty, like all duties, is in the Present. This is now straw splitting. He does not want men to give the Future their hearts, to place their treasure in it. We do. His ideal is a man who, having worked all day for the good of posterity (if that is his vocation), washes his mind of the whole subject, commits the issue to

Heaven, and returns at once to the patience or gratitude demanded by the moment that is passing over him. But we want a man hagridden by the Future — haunted by visions of an imminent heaven or hell upon earth — ready to break the Enemy's commands in the Present if by so doing we make him think he can attain the one or avert the other — dependent for his faith on the success or failure of schemes whose end he will not live to see. We want a whole race perpetually in pursuit of the rainbow's end, never honest, nor kind, nor happy now, but always using a mere fuel wherewith to heap the altar of the Future every real gift which is offered them in the Present."

The Screwtape Letters
— C.S. Lewis

The "planners" are "planning" our lives. Our future. It has been going on for a while now, this intensive effort to revise, to redirect, to reform the "Health Care System" of our country. Only now, however, do these many plans begin to take shape and break through the quiet surface of the sea beneath which they have slumbered unnoticed these past few years. The shape they take will to a greater or lesser degree give outline and direction to the practice of medicine for the foreseeable future.

Perhaps it started, was birthed, in 1965 when we devised Medicare out of our concern for providing proper health care for the elderly amongst us. The changes, the concern, was there before that time, but subtle, and we paid little attention to them. Now, though, we made a statement. We said in effect that a certain segment of our population, those beyond 65 years, would be assured of health care and this regardless of ability to pay in kind for that care. Should it astound any of us that from this single decision there would grow the demand, the reasonable expectation, that if one segment of our population received such attention then why not other groups? Indeed, why not all of us? We expanded the "coverage" to those in most obvious need. To the poor and the lame and the blind. We physicians supported that expansion, and to our credit, for after all we were the ones who through history had stood as the bulwark against those who would deny proper medical care to the masses. We were the ones who prided ourselves in taking care of the sick regardless of ability to pay. Perhaps the seed of self destruction was planted in 1965 by a Federal dictum that said to us that we must accept a monetary reward for services which throughout the ages had been rendered by the physician free of charge to those unable to pay for their medical care. The distance from that position to the posture of expecting payment for all of our services to everyone seems today but a trifle.

And so we come at this time in our lives to that point where the clamor to reform the health care system of our country reaches a crescendo. To the point where we find plans and schemes and suggestions and proposals too numerous to recount. The major ones are enough to give one pause. The *"Social Security Advisory Commission"* — the Steelman Commission — has developed a proposal to reorganize Medicare with "Part I" dealing with non-catastrophic expenses and "Part II" with catastrophic ones. The recently released *"Pepper Commission"* report — the *"United States Bipartisan Commission On Comprehensive Health Care"* — advocates universal access to coverage of acute care under a pluralistic system mandating employer participation for coverage of employees and a federally financed and administered public plan replacing Medicaid. The *"National Leadership Commission On Health Care"* — composed of 38 corporations, unions, insurers and foundations talks of a nationally determined level of basic health care services provided by a consortium of employers and government. The *"AFL-CIO Plan"* calls for passage of a national health care program. The *"Heritage Foundation"* proposal talks of a *"National Health System for America."* The *"Consumer Choice Health Plan"* for the 1990s is an attempt to apply basic principals of market competition to health care delivery and financing while the *"Physicians for a National Health Program"* developed by a group of 432 physicians from nearly every state representing most medical specialties and the practice settings suggests universal coverage for everyone under a single public plan.

As though this surfeit of suggestions was not enough, there comes to us the ideas of the AMA and the AHA. They all, these "plans," have a common thread, you see. They talk of those basic characteristics of any manner of caring for the sick. They talk of "Access" — of "Quality" — and of "Affordability." They use those terms now as part of our medical vocabulary — "uncompensated care" — "contractural

adjustment" — "consumer" — "provider" — "medically indigent."

Therein lies the challenge to us all. That is, should we desire to face that challenge. To accept that charge. Are we willing to provide "access" to everyone? Reasonable and reliable and dependable access provided in a dignified manner? Can we develop a method to study and monitor quality in an efficient and practical manner? Are we willing to seriously recognize cost — affordability — as the pragmatic roommate and companion of both access and quality? The gauntlet has been thrown down before us. We have talked in our past of our willingness, indeed of our determination, to care for the sick wherever and whenever we encountered them and without regard to their ability to reimburse us monetarily for that care. We have enjoyed the reputation of always providing quality care to the point that we lived our lives in an atmosphere of unguarded and unregulated freedom. The "Health Care System" of our future designed in concert with others will ask, indeed will demand, that access to that "System" be reasonably available to all of our population of whatever economic strata. That reimbursement for that care be affordable to those with means to pay us themselves either directly or through a third party payor. Finally, that we help develop and participate in the system whereby the consistent work of our labors, the quality, assumes a position of trusted integrity. Surely there will flow from such a "System" a sense of worth that will attract to the practice of medicine those individuals best suited both morally and intellectually to this high calling and provide for them a monetary reward consistent with their labors.

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- an educational program entitled, "Building Effective Hospital Physician Relationships: Ten Success Stories"; Stephen M. Shortell, Ph.D. will present the results of his study on the working relationships between ten selected hospitals and their medical staffs;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including the Impact of Hospital Bankruptcy, the Role of Hospital Governing Boards in Professional Review, and Information Sharing Among Medical Staffs;
- recommendation of policy to the House of Delegates on Prioritization of Health Care Expenditures and Notification of Denials by the PRO;
- AMA-HMSS Governing Council elections for the positions of Chairman, Vice-Chairman, Secretary, and one Member-at-large.

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HMSS

An Open Letter to the Georgia Medical Care Foundation and the Department of Medical Assistance

(A Medicaid precertification program was instituted in Georgia effective March 1, 1990. The Georgia Medical Care Foundation (GMCF) will manage this program in accordance with the policies of the Department of Medical Assistance (DMA). During the week of February 12-16, 1990, GMCF sponsored sessions across the state of Georgia to give Providers "an opportunity to discuss the policies and procedures of the precertification program.")

Dear Sirs,

Thank you for your efforts to enhance understanding of the new precertification requirements being enacted by the Department of Medical Assistance. It was my pleasure to attend the information session held in Augusta. Your representatives did an admirable job of explaining many of the questions that the 100 or so members of the audience had concerning which procedures would be subject to review, how to submit claims, procedures for appeal, and the steps which GMCF has taken to insure a smooth and efficient system.

It was quite evident from answers to questions asked in that session that this program will require a significant amount of time on the part of Providers in obtaining precertification. In an effort to better understand the goals and purposes of precertification (which I assume are primarily to reduce rising medical costs), I asked questions about the financial reasoning behind this program — certainly relevant to a forum intended to provide "an opportunity to discuss the policies and procedures of the precertification program." No one representing GMCF was able to answer a few basic questions, except to sheepishly offer that precertification would "probably save money." At that point in the meeting, several other members of the audience raised similarly pertinent questions. After attempting to answer a few, the meeting was abruptly dismissed by a GMCF representative "since the purpose of the meeting (was) to discuss precertification, and we have answered all your questions," despite the fact that a question remained open on the floor and more than 1 hour of time remained for the scheduled session. I feel compelled, therefore, to restate the following questions.

"It was quite evident from answers to questions in that session that this program will require a significant amount of time on the part of Providers in obtaining precertification."

1. "What is the projected cost to DMA or GMCF for operating the precertification program during the first year?"

With the creation of 15 incoming telephone lines and nine outgoing lines, review personnel, information sessions, and many other items certainly a significant cost will be incurred. Fiscal responsibility mandates that such a projection be drawn up before implementing a new program. The answer offered by your representative was that the costs could be determined after the first 3 to 5 months of operation, but he was unaware of any projected budget.

2. "What are the projected first year savings to DMA from operating the precertification program? How much of these savings will be the result of a decrease in the number of services by Providers versus the number of services provided but not pre-approved, and thus not

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eligible for reimbursement by DMA?"

Obviously, the savings to DMA for operating this program must be greater than the cost of the program, to justify it from a financial point of view. Also, will the savings be long term as a result of fewer actual procedures, or short term as Providers learn to "play the game" and meet all precertification requirements?

3. "What is the projected first year cost to Providers as a result of time required of physicians and/or support staff in fulfilling precertification requirements?"

While the costs to DMA are important, the costs to the Providers certainly merit careful consideration. No program should be implemented which will adversely affect the number of participating providers, reducing access to health care of those who need it the most. We have been told that an additional fee for precertification costs cannot be billed separately. It is very unlikely that reimbursement from DMA to Providers will increase adequately to off-set these costs. Certainly you can't expect Providers to absorb all these costs. Instead hospitals and doctors will be forced to pass these costs on to private-pay patients. Knowing the cost of this program to Providers would make it easier to explain to patients why medical costs continue to spiral faster than the rate of inflation.

4. "After the initial year of operation, will a review of the actual costs and savings outlined above be reported to Providers?"

As a taxpayer I encourage, expect, and applaud implementation of policies and programs which result in maximal economic efficiency for any state expenditures. The need for such efficiency is not at all questioned. Such a program, however must be fair to those who serve it. Only then can we guarantee that Medicaid recipients will continue to have access to quality medical care in the future.

Respectfully submitted,
David L. Anders, MD

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Behavioral and Pharmacologic Management of Patients with Alzheimer's Disease

Neil Kahn, M.D., Alan Stoudemire, M.D.

It is becoming increasingly important for primary care physicians to be able to manage patients with dementia, since the number of cases of dementia will reach almost epidemic proportions in the next century. The fastest growing portion of our population is the group aged 65 and over, and it is expected to increase from the current estimated level of 25 million to 52 million by the year 2030, with a corresponding increase in age-associated disorders such as dementia.[1] Unless a curative treatment is found for Alzheimer's disease, the devastating effect of this illness on society and the medical system will continue to grow.

Approximately 6% of the population over the age of 65 currently suffers from Alzheimer's disease, which accounts for 50 to 60 percent of severe dementias.[2] Most of these patients will initially be managed in the home for long periods of time. Currently, for every person with dementia over 65 in a nursing home there are two living in the community. Approximately half of the nursing home beds in Georgia are filled with patients with dementing illness. Family caregivers provide as much as 80% of the care required by the frail elderly. Most often this is the spouse, followed by children, and then other family members and friends.[3] Typically, one person must serve as the primary caregiver.

Initially, the manifestations of a dementing illness may be subtle cognitive deficits which may be unrecognized or denied by the patient and family. It is imperative that the assessment include a formal mental status examination.

Drs. Kahn and Stoudemire are with the Department of Psychiatry, Emory University School of Medicine, Atlanta. Send reprint requests to Dr. Stoudemire at the Section of Psychiatry, Emory Clinic, 5th Floor, 1365 Clifton Rd., NE, Atlanta, GA 30322.

The burden of caregiving for these patients leaves caregivers with poor self-reported health status in comparison to others of similar age in the community.[3] Caregivers report two to three times the use of psychotropic medications, increased psychiatric symptoms (including depression), lower incomes, and greater isolation than similar community residents.[3]

There are currently inadequate community resources to provide skilled care assistance either in nursing homes or private homes for all of the severely demented patients. Even when there is space available in a personal care or nursing home, it may prove to be at a devastating cost (approximately $12,000-$14,000/year for a personal care home and $20,000-$24,000/year

TABLE 1 — Mini-Mental State Examination and Instructions

Patient _____
Examiner _____
Date _____

MINI-MENTAL STATE EXAMINATION

Maximum Score	Score	
		ORIENTATION
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we: (state) (county) (town) (hospital) (floor)?
		REGISTRATION
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he learns all 3. Count trials and record. Trials _____
		ATTENTION AND CALCULATION
5	( )	Serial 7's. 1 point for each correct. Stop after 5 answers. Alternatively spell "world" backwards.
		RECALL
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct.
		LANGUAGE
9	( )	Name a pencil, and watch (2 points) Repeat the following "No ifs, ands or buts." (1 point) Follow a 3-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor" (3 points) Read and obey the following: CLOSE YOUR EYES (1 point) Write a sentence (1 point) Copy design (1 point)
_____		

TOTAL SCORE — Perfect score = 30; Any score below 25 indicates the presence of significant cognitive dysfunction.

ASSESS level of consciousness along a continuum: Alert — Drowsy — Stupor — Coma.

Patients with dementia who display severe agitation, paranoia, and other psychotic symptoms are usually treated with neuroleptic agents.

for a nursing home). An estimated 20% of older Americans are classified as poor or near the poverty level.[4] In Georgia, to be eligible for Medicaid support for the limited number of nursing home beds available for Medicaid recipients, the combined monthly income of the patient and spouse must be less than $1,000 per month and assets, excluding the home, must not exceed $1,900. Many see their life savings evaporate as they "spend down" their assets on nursing home expenses for a demented spouse until that spouse becomes Medicaid eligible. Hence, Alzheimer's disease imposes a massive financial stress on victims of the disease and their families.

Medical Assessment

Physicians play a critical role in the care of the Alzheimer patient and their families at every stage of the illness. Most patients with evolving dementia present to the physician accompanied by a family member. Initially, the manifestations of a dementing illness may be subtle cognitive deficits which may be unrecognized or denied by the patient and family. It is imperative that the assessment include a formal mental status examination. A useful and well known screening test of this type is the Mini-Mental State Examination developed by Folstein, et al. on which a score of 24 or less out of a possible 30 generally suggests clinically significant cognitive impairment[5] (Table 1).

It is equally important before the diagnosis of Alzheimer's disease is made to perform an evaluation for causes of cognitive dysfunction which are potentially reversible (Table 2). The diagnosis of Alzheimer's disease is one of exclusion, and the definitive diagnosis can only be made by postmortem neuropathologic assessment. It is found to be the cause for 70 to 80% of dementias.

Research Strategies in Pharmacologic Treatment for Alzheimer's Disease

Most pharmacologic research in the treatment of Alzheimer's disease is based upon the observation that when normal subjects are given potent anticholinergic agents, they can manifest memory impairment not unlike that which is seen in patients with Alzheimer's disease. Patients with Alzheimer's disease have also been shown to have characteristic neuropathologic changes to a marked degree in the nucleus basalis of Meynert early in the course of the illness. The neurons in the nucleus basalis produce and utilize acetylcholine as a primary neurotransmitter with projections

to widespread areas of higher cognitive functions throughout the brain. Attempts to augment cholinergic function in a way analogous to the use of L-Dopa for the treatment of Parkinson's disease have been largely inconclusive as of this date.

Lecithin contains phosphatidylcholine which in combination with acetyl-coA is catalyzed by choline acetyltransferase into acetylcholine. Large doses of lecithin have been used in Alzheimer's patients in the hope that an increase in the rate of acetylcholine synthesis will occur. Choline has also been given, but when excreted in perspiration and metabolized by bacteria on the skin, produces a foul, fishy odor which is objectionable to patients and those around them. Studies in which lecithin, choline, or phosphatidylcholine have been given to patients with Alzheimer's disease have been equivocal. Some evidence has suggested that lecithin may slow the rate of cognitive deterioration with long-term trials, and occasional patients appeared to improve to some degree, especially those with mild symptoms of early Alzheimer's disease.[6] These improvements, however, have not been demonstrated to be either clinically significant or maintained.

Physostigmine is a cholinergic agonist which has been given by mouth, subcutaneously, and intravenously in an attempt to enhance memory function. The results of various studies are mixed—some patients demonstrated significant improvement, others did not. In all patients, the half life of physostigmine is short, requiring frequent administration, and it does not slow the rate of deterioration.

Bethanecol is another acetylcholine agonist which has been given by intracranial infusion to four patients associated with some improvement in confusion, initiative, and ability to perform activities of daily living. All patients tend to experience nausea, and others have been reported to have Parkinsonian rigidity and bradykinesia.[7]

Instructions for Administration of Mini-Mental State Examination

Orientation

(1) Ask for the date. Then ask specifically for parts omitted, e.g., "Can you also tell me what season it is?" One point for each correct.

(2) Ask in turn "Can you tell me the name of this hospital?" (town, county, etc.). One point for each correct.

Registration

Ask the patient if you may test his memory. Then say the names of 3 unrelated objects, clearly and slowly, about one second for each. After you have said all 3, ask him to repeat them. This first repetition determines his score (0-3) but keep saying them until he can repeat all 3, up to 6 trials. If he does not eventually learn all 3, recall cannot be meaningfully tested.

Attention and Calculation

Ask the patient to begin with 100 and count backwards by 7. Stop after 5 subtractions (93, 86, 79, 72, 65). Score the total number of correct answers.

If the patient cannot or will not perform this task, ask him to spell the word "world" backwards. The score is the number of letters in correct order, e.g., dlrow = 5, dlorw = 3.

Recall

Ask the patient if he can recall the 3 words you previously asked him to remember. Score 0-3.

Language

***Naming:* Show the patient a wrist watch and ask him what it is. Repeat for pencil. Score 0-2.**

***Repetition:* Ask the patient to repeat the sentence after you. Allow only one trial. Score 0 or 1.**

***3-Stage command:* Give the patient a piece of plain blank paper and repeat the command. Score 1 point for each part correctly executed.**

***Reading:* On a blank piece of paper print the sentence "Close your eyes," in letters large enough for the patient to see clearly. Ask him to read it and do what it says. Score 1 point only if he actually closes his eyes.**

***Writing:* Give the patient a blank piece of paper and ask him to write a sentence for you. Do not dictate a sentence, it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.**

***Copying:* On a clean piece of paper, draw intersecting pentagons, each side about 1″, and ask him to copy it exactly as is. All 10 angles must be present, and 2 must intersect to score 1 point. Tremor and rotation are ignored.**

Estimate the patient's level of sensorium along a continuum, from alert on the left to coma on the right.

Used with permission from Folstein MF, Folstein SE, McHugh PR: "Mini-Mental State" A practical method for grading the cognitive state of patients for the clinician. J Psychiat Res 1975;12:189-198 (Pergamon Press plc, Great Britain).

TABLE 2: Comprehensive Workup of Dementia and Delirium

A. Physical exam, including thorough neurologic exam
B. Vital signs
C. Mental Status Examination
D. Mini-Mental State Exam (MMSE)
E. Review of medications and drug levels
F. Blood and urine screens for alcohol, drugs, and heavy metals[a]
G. Physiologic workup
   Serum electrolytes/Glucose/Ca^{++}, Mg^{+}
   Liver, renal function tests
   SMA-12 or equivalent serum chemistry profile
   Urinalysis
   Complete blood cell count with differential cell type count
   Thyroid function tests (including TSH level)
   RPR (serum screen)
   FTA-ABS (if CNS disease suspected)
   Serum B12, (consider serum methylmalonic acid and total serum homocysteine[a])
   Folate Levels
   Urine corticosteroids[a]
   Erythrocyte sedimentation rate (Westergren)
   Antinuclear antibody[a] (ANA), C_3C_4, Anti-DS[a] DNA[a]
   Arterial blood gases[a]
   HIV screen[a, b]
   Urine porphobilinogens[a]
H. Chest X ray
I. Electrocardiogram
J. Neurologic workup
   CT or MRI scan of head[a, c]
   SPECT[d]
   Lumbar puncture[a]
   EEG[a]
K. Neuropsychologic testing[e]

[a]If indicated by history and physical examination
[b]Requires special consent and counselling
[c]See Table 2-10 for relative discriminating power
[d]May detect cerebral blood flow perfusion deficits
[e]May be useful in differentiating dementia from other neuropsychiatric syndromes if this cannot be done clinically.

Used with permission from Stoudemire A. Organic mental disorders. In, Clinical Psychiatry for Medical Students. Edited by Stoudemire A. Philadelphia, J. B. Lippincott, 1990.

Tetrahydroaminoacridine (THA) is a centrally acting anticholinesterase which does not produce some of the undesirable peripheral anticholinergic effects of physostigmine. Results of early studies of lecithin and THA in combination have been controversial and complicated by hepatotoxicity. There is an investigational protocol in Georgia which can be accessed through the Departments of Psychiatry and Neurology at the Medical College of Georgia in Augusta and Emory in Atlanta. Almost all studies which suggest improvement for patients with Alzheimer's disease given acetylcholine augmenting agents also suggest that any benefits are limited to early in the course of the disease, implying that their efficacy may be limited to that period when there remain some normally functioning acetylcholine neurons.

Hydergine is a mixture of four ergot alkaloids, and the only FDA-approved drug for the treatment of cognitive decline currently available. It was first marketed in the 1950s as a vasodilator, acting as an alpha adrenergic antagonist. It may also act as a partial dopamine and serotonin agonist. Although unspectacular in efficacy, a few reports suggest the drug may slow deterioration of dementia—although its efficacy remains controversial and relatively poorly substantiated.[6-8]

Practical Management Strategies

While there is as yet no established treatment to halt or reverse the deterioration associated with Alzheimer's disease, this does not justify a wholly nihilistic response to the illness. There may be particular symptoms which cause disproportionately more difficulty than others for those providing care to these individuals, and certain physician interventions can be of great help to caregivers.

Educating the family as to the longitudinal course of Alzheimer's disease can allow early planning for future complications. Families unaware of the typical manifestations of the disease and its progressive nature will be more likely to be alarmed and seek emergency evaluation for new symptoms as they arise. Written materials prepared for families of patients with Alzheimer's disease, such as "The 36-Hour Day," can be useful in providing insight into the nature of the illness and management tips for the caregiver.[9] In addition, families should be referred for legal and financial counseling for future planning as soon as there is reasonable clinical evidence to suspect the diagnosis.[10]

It is important for the physician to ascertain precisely what led to the patient being brought in for medical evaluation. Typically, troublesome new symptoms have developed or a recent change in the environmental support has occurred. Patients should be evalu-

ated and families interviewed in parallel to determine how the patient's clinical status has changed and with what symptoms they are presenting. Specifically, it is necessary to ascertain what specific behaviors or symptoms complicate the patient's management in the environment in which they happen to reside.

Patients need to have a medical assessment as well. Although they may be unable to provide a coherent history or review of systems, it is not uncommon for demented patients to present with increasing confusion, agitation or lethargy when suffering from an underlying infection, myocardial infarction, metabolic disorder, drug reaction, or occult injury.

Patients with dementia are unquestionably more sensitive to adverse effects of medications due to their loss of functional neurologic reserve. The presence of a drug-induced delirium (acute organic brain syndrome) should be considered when abrupt deterioration occurs in the demented patient.[11] It is important to note any recent change in dose or type of medication prescribed to the demented patient. Medications which commonly cause adverse effects on mental status include anticholinergic effects, steroids, sedative hypnotics, or dopamine agonists used to treat Parkinson's disease.

Behavioral Problems in Dementia

Patients with dementia can develop systematized delusions and hallucinations (most commonly auditory or visual) associated with agitation, physical aggression, sleeplessness, and increased confusion as a primary complication of their brain disease. These symptoms can result in the patient presenting an imminent danger to themselves and others, or so complicate the provision of necessary assistance with their activities of daily living that inpatient admission for evaluation and management may be indicated. In the hospital or nursing home settings, certain environmental interventions which can be of benefit to such patients includes one-to-one staffing with frequent reorientation of the patient. A dark room can exacerbate perceptual disturbance through sensory deprivation, so low lighting or a night light in the evening is preferable to a totally dark room.

Almost all studies which suggest improvement for patients with Alzheimer's disease given acetylcholine augmenting agents also suggest that any benefits are limited to early in the course of the disease . . . when there remain some normally functioning acetylcholine neurons.

Patients tend to be less confused at home than in unfamiliar environments. The memory loss in Alzheimer's disease affects the ability to form new memories and short-term recall in a relatively selective fashion early in the illness, while memory for events previous to the onset of cognitive deterioration are relatively preserved. Keeping patients in familiar environments and minimizing even simple alterations, such as rearranging furniture or allowing clutter to collect, can allow patients to function more independently.

Conversely, patients may become increasingly agitated and confused when put in an unfamiliar environment, including the hospital. Familiar objects such as photographs can be brought from home to surround a confused patient, and at times help to calm and re-orient. Clocks and calendars should be displayed prominently to help reorient the patient, along with special signs indicating place and circumstance. Staff interacting with the patient should identify themselves frequently and dress appropriately. Vision and hearing should be assessed and optimized with glasses or hearing aids if appropriate and available. Poor hearing, in particular, has been associated with an increased risk for paranoia in later life, presumably by contributing to the patient's misinterpretation of his/her environment. In some areas, organizations such as the Lions Club make funds available to provide hearing aids for individuals otherwise unable to afford them.

At times, it may be necessary to use physical and/or pharmacologic restraint to perform an adequate assessment and assure the patient's safety, with the precaution that patients in restraint should not be left unattended. Prolonged physical restraint predisposes to myonecrosis and deep venous thrombosis and should be avoided, but these risks must be weighed against the patient's risk for self injury while agitated and confused.

Psychosis in the patient with dementia tends to be worse in the evening ("sundowning") and can be exacerbated by a disturbed sleep/awake cycle. Evenings can be "nightmares" for caretakers in which they can anticipate little restful sleep while attending an agitated and obstreperous patient. At times, a non-specific sedative can normalize the pattern of sleep and control the worst of the psychotic symptoms.

Patients with Alzheimer's disease can display physical aggression towards others or have poor impulse control resulting in various types of destructive outbursts. When this occurs in the Alzheimer's patient, it is important to know the circumstances in which these take place.

If they present in the context of psychosis in reaction to some delusional fear or hallucinatory experience, a neuroleptic (antipsychotic) agent may be indicated. Aggression is often seen during periods of increasing confusion and worse at night. Travel or moving the patient to an unfamiliar environment can exacerbate confusion and predispose to such outbursts.

Patients should be evaluated and families interviewed in parallel to determine if the patient's clinical status has changed and with what symptoms they are presenting.

Depression should be considered in the differential diagnosis of dementia, particularly in patients with a personal or family history of depression or alcohol abuse, which have been associated with an increased risk for depressive illness.[12] In addition, major depressive episodes are commonly a sequelae of stroke, and are also seen in certain conditions such as Parkinson's disease.[13] Whether this proves to be true or not, it is still worthwhile to consider a trial of antidepressant medication in an attempt to optimize mental status for patients with symptoms suggesting this possibility, including emotional lability, anxiety, sleep and appetite disturbance, and depressive ruminations.[14]

Supportive Care

There are families for whom it would appear to be best that the patient be referred to a nursing home in the middle to latter stages of the illness, usually 2-4 years after symptoms have become evident. At times, even when this is readily apparent to clinicians, families are reluctant to consider this option. At other times, patients are brought for evaluation by the physician, and it soon becomes clear that while things have changed little in terms of the patient's neurologic status, the caregiver has become increasingly weary of the responsibility of patient management, although unable to admit this to the clinician or themselves. There are support groups in the community such as those run by the Alzheimer's Association for caregivers, spouses, and family members of patients with Alzheimer's disease which can be of great benefit to such individuals. It is not unusual for latent family conflicts previously quiescent to come to the surface under the stress of caring for a dementing parent or spouse, and in situations where patient's families seem to be acting inappropriately or irrationally. At all times, though, it should be remembered that caregiving for a demented individual can be a thankless and difficult task, and sometimes just having the regular opportunity to ventilate frustrations inherent to this role can be therapeutic for the caregiver for the Alzheimer's patient and well worth their making a regular trip to the physician's office.

Practical Approach to Psychopharmacologic Management

The decision to use any psychopharmacologic agent should be based on the following major factors:

1) The patient's primary psychiatric diagnosis
2) The "target symptoms" that require modification or suppression
3) Vulnerability of the patient to side effects
4) Therapeutic efficacy and side effect profile of the drug being considered for therapy.

In the context of dementia, the behavior that can be partially modified by psychopharmacologic agents is restricted. The most common symptoms that may at least partially respond to drug treatment include:

1) Anxiety
2) Depression
3) Severe agitation and aggressive behaviors
4) Psychotic symptoms
5) Insomnia

If adjunctive sleep medication is needed, the benzodiazepines are probably the most common drugs employed for this purpose.

Anxiety

While in most patients, symptoms of acute and chronic anxiety in the absence of depression are most commonly treated with benzodiazepines, these drugs should be used conservatively in patients with dementia. The primary reason for this conservative approach is to avoid exacerbating cognitive dysfunction that may be a side effect of benzodiazepines which may occur even in elderly patients who have no evidence of dementia. There is little evidence that any one benzodiazepine has advantages over another, unless the patient has liver disease—in which case the shorter acting benzodiazepines primarily metabolized extra-hepatically by gluconide conjugation are preferred (oxazepam, lorazepam). These shorter acting drugs, however, must be given two or three times a day to maintain steady state serum levels.

Buspirone is a new non-benzodiazepine anxiolytic that is not habit forming and has almost no side effects. It takes 2-3 weeks to reach maximal effect and is given in doses of 20-60 mg/day in divided doses.

Clinical experience with this drug in patients with dementia is limited to date but it may be of significant benefit for agitated demented patients, although a lag time of 10-14 days may occur before it takes effect.

Depression

Patients with dementia are not immune to depression, yet depressive symptoms may be overlooked in patients with dementia since such symptoms as apathy, withdrawal, insomnia, and anxiety may be falsely attributed to the effects of dementia. If an antidepressant is used, those with relatively low anticholinergic effects, such as desipramine or nortriptyline, are preferred. The new bicyclic agent fluoxetine is a more "activating" antidepressant that is devoid of anticholinergic side effects. Fluoxetine is given in a single daily 20 mg dose in the morning and generally does not require any increase in dosage. Trazodone is a sedating antidepressant that can be given at bedtime, but with a snack since it can cause gastric irritation. This drug has also been used in the dose ranges of 100-300 mg as a treatment of agitation even when depression has not been a part of the clinical picture. Doxepin is another effective antidepressant that is helpful for agitated depressed patients with insomnia despite the presence of mild anticholinergic effects.

Most pharmacologic research in the treatment of Alzheimer's disease is based upon the observation that when normal subjects are given potent anticholinergic agents, they can manifest memory impairment not unlike that which is seen in patients with Alzheimer's disease.

Agitation/Aggressive Behavior and Psychotic Symptoms

Patients with dementia who display severe agitation, paranoia, and other psychotic symptoms are usually treated with neuroleptic agents (Table 3). They should be admin-

TABLE 3 — Side Effect Profiles and Dose Equivalents of Commonly Used Neuroleptics

Drug	*Equivalent Dose (mg)*	*Dosage Forms*	*Sedative*	*Side Effects*		*Anticholinergic*
				Extrapyramidal	*Hypotensive*	
Phenothiazines						
Chlorpromazine	100	t,i,c,s,r	+ + +	+ +	IM + + + oral + +	+ + +
Thioridazine	95	t,c,s	+ + +	+	+ +	+ + + +
Mesoridazine	50	t,i,c	+ + +	+	+ +	+ + +
Fluphenazine	2	t,i,d,s,c	+	+ + +	+	+
Perphenazine	10	t,i,c	+ +	+ +	+	+
Trifluoperazine	5	t,i,c	+	+ + +	+	+
Butyrophenones						
Haloperidol	2	t,i,c,d	+	+ + +	+	+
Thioxanthenes						
Thiothixene	5	t,i,c	+ to + +	+ +	+ +	+
Dihydroindolone						
Molindone	10	t,c	+ +	+	0	+
Dibenzoxazepine						
Loxapine	15	t,i,c	+	+ +	+	+ +
Diphenylbutylpiperidine						
Pimozide*	2	t	+	+	+	+
Clozapine	50	t	+ + +	0	+ +	+ + + +

0 = none, + = slight, + + = moderate, + + + = marked, + + + + = pronounced
t = tablet or capsule, i = injectable, c = concentrate, s = suspension, r = rectal suppository, d = depot injection
*Pimozide may have a greater propensity for prolonging the QT interval than other neuroleptics
Information in table extracted in part from:
Mason A & Granacher RP (1980). *Clinical Handbook of Antipsychotic Drug Therapy*. New York: Brunner/Mazel, pp. 19-108.
and
Baldessarini RJ (1978). Chemotherapy. In Nicholi AM (ed). The Harvard Guide to Modern Psychiatry. Cambridge: Harvard University Press, p. 390.

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istered in the lowest dose possible and for short periods of time, unless the patient has clearly demonstrated the need for long-term maintenance therapy. Elderly patients are especially prone to the drug-induced Parkinsonian syndrome with these agents. The "high potency" neuroleptics such as haloperidol, thiothixene, fluphenazine are especially prone to cause extrapyramidal side effects (EPS). On the other hand, thioridazine or chlorpromazine cause less EPS but are more likely to cause orthostatic hypotension and have more anticholinergic side effects than their "higher potency" counterparts such as haloperidol. Drugs in the "mid-range" of side effects include loxitane and molindone—relatively more expensive but underused drugs for the purpose of managing agitated and psychotic symptoms in patients with dementia.

The presence of drug-induced delirium (acute organic brain syndrome) should be considered when abrupt deterioration occurs in the demented patient.

Insomnia

Insomnia is perhaps the most common problem that physicians will be asked to modify with medication in patients with dementia, since fragmentation and reversal of the diurnal sleep/wake cycle is a common clinical finding in Alzheimer's disease. Before considering medication for insomnia, a few practical suggestions can help enhance the likelihood of sleep at night and include:

a) Avoiding daytime napping

b) Avoiding coffee and other sources of caffeine with the possible exception of the equivalent of one cup of coffee in the early morning hours.

c) Avoiding the use of sedating medications during the daytime and reserving psychotropic drug dosing for the late evening hours.

If adjunctive sleep medication is needed, the benzodiazepines are probably the most common drugs employed for this purpose. If a neuroleptic agent is already in use for psychotic symptoms or severe agitation, one may try giving all of the neuroleptic dose in a single evening dose first before proceeding to an adjunctive soporific. If this fails, one may then proceed to other medications. Of the available benzodiazepines, temazepam, flurazepam, and triazolam are currently marketed for sleep induction. Flurazepam should in general be avoided due to an excessively long half-life and the tendency to accumulate and cause confusion. Triazolam is an ultra-short acting drug with a half-life of 2-4 hours. If triazolam is used it should be used in very low doses (0.125 mg or less), since in higher doses it may cause confusional states and anterograde amnesia. Temazepam has a half-life of 12-16 hours, and its metabolism is not affected by aging or liver disease. Temazepam is more slow acting than the previous two benzodiazepines discussed above, and in the elderly it should generally be used in the 15 mg dose form.

Alternative drugs for sleep include the sedative-hypnotic chloral hydrate in the doses of 500-1000 mg. Chloral hydrate is benign from the side effect profile but may not sustain sleep throughout the night. Sedating antihistamines such as diphenhydramine and hydroxyzine should generally be avoided because of their moderately potent anticholinergic effects.

Summary

While as yet there are no proven effective primary treatments for Alzheimer's disease, physicians play a critical role in the evaluation and long-term supportive care of these patients and their families. The physician also plays a pivotal role in helping the patient make management decisions regarding their loved one such as organizing the process of nursing home placement in the more advanced phases of the illness. In addition, physicians provide a focal point for triage community support resources, such as the Alzheimer's Association. When necessary, the judicious and conservative use of psychopharmacologic agents can serve to partially diminish the pervasive behavioral complications of this illness.

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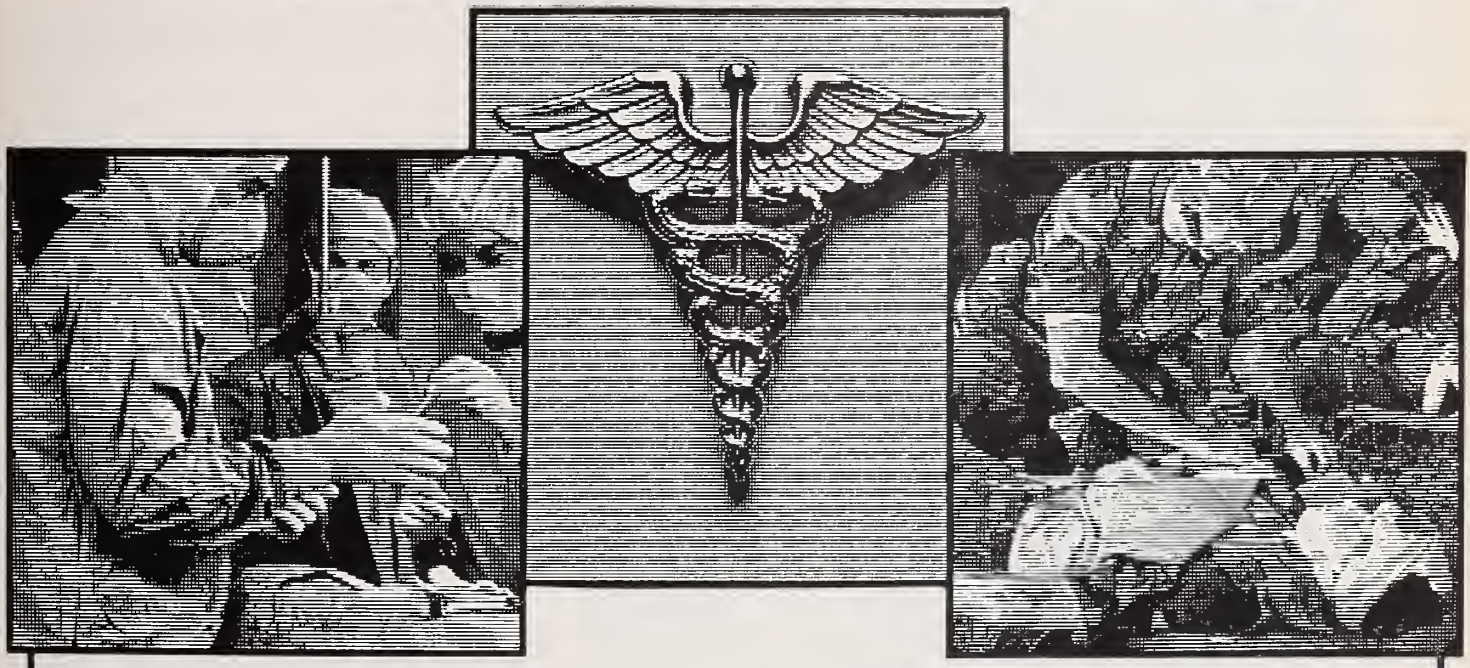

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Still Attached — Thoughts on Art, Disease, and Dying

Noah D. Meadows, Jr., M.D.

"Toward the person who has died we adopt a special attitude: something like admiration for someone who has accomplished a very difficult task."

SIGMUND FREUD

"This is a terrible time to die. Death has never been so mysterious, so obscene or shameful an occupation as it is in our time."

GERMAINE GREER

Dear Mother, Don't worry, if I die I'll only be dead.

LETTER FROM CONFEDERATE SOLDIER

There is an old story that Plato, on his deathbed, was asked by a friend if he would summarize his great life's work, the Dialogues, *in one statement, Plato, coming out of a reverie, looked at his friend and said, "Practice dying."*

WHAT HAPPENS when someone you know or take care of becomes very ill but is "still attached" to this life?

While looking through the original art at the Frameworks Galley in Marietta in search of a gift for my long-time friend, Dr. Elizabeth Kubler-Ross, I came upon a compelling watercolor of an apparently diseased (or very old) apple with diseased/old leaves. The artist, Stan Horton, of Cartersville, had given the painting the somewhat challenging, at least to those of us who do or have been faced with the care, of a chronically ill relative or friend, the title, *Still Attached.* Very perceptively, the apple is portrayed as casting a very distinct shadow — the same shadow — on its environs as that cast by a healthy apple. Though diseased, the same shadow is cast, and the same water and food (the same love and care) is required for that fruit (person) if the best possible existence is to be experienced until the life breath is extinguished.

Dr. Kubler-Ross remarked to me during her first visit to the Cobb County Symposium in 1972, about the 1969 publication date of her seminal book, *On Death and Dying,* "Noah, it's a matter of timing. If I had written it 5 years ago, no one would have read it, and if I had written it 5 years later, there would have been dozens just like it."

In Atlanta recently to speak at a health symposium cosponsored by the Metropolitan Atlanta Foundation and the Atlanta Church of Religious Science, she referred to her now-famous five "Stages of Dying" (denial and isolation; anger; bargaining; depression; and acceptance) in a somewhat humorous way. She recalled the comments made by a health care professional who had just observed a terminally ill hospital patient as being in the "classic stage of anger." In actuality, according to Dr. Kubler-Ross, the patient was angry at having been suddenly awakened at 5 a.m. by a nurse who asked him, "And how are *we* feeling today?"!

Dr. Meadows is a retired internist. His address is 509 S. Woodland Dr., Marietta, GA 30064.

Dr. Noah Meadows (L) and Mr. Stan Horton, the artist from Cartersville who painted the watercolor they're holding "Still Attached." The image depicts a diseased (or very old) apple "still attached" to the stem and stimulates some provocative thoughts by Dr. Meadows.

Back to the shadow the fruit/person casts on those around it/him/her. It casts the shadow of the same five stages referred to above. I remember my own difficulties in working through these stages when my parents were dying. My long-smoking father was dying of lung cancer, my mother of an Alzheimer's-like disease. In her case, especially, I was faced with the experience of being with the "live" body of a person I had known and loved who had long since departed from any meaningful relationship with life, yet was "still attached."

We are often reminded of Dr. Kubler-Ross's comment's regarding timing — whether one happens to be on the road at a certain hour, having been delayed by a phone call or whatever — when a drunk driver crashes into your car. It's not quite as obvious to observe the timing with terminal illnesses such as cancer or AIDS. But in the end, whether it involves being connected to a life-support system resulting from an accident or fatal disease, we still have to deal with questions related to that person being "still attached."

I was faced with the experience of being with the "live" body of a person I had known and loved who had long since departed from any meaningful relationship with life, yet was "still attached."

The famed illustrator, N. C. Wyeth, said, "Art is not what you do, it is what you are." Michael Wood, in the recent PBS-TV Series, "Art of the Western World," commented, "Art has served as a physical and spiritual bridge between mortals and gods, has helped men and women understand the workings of the human soul and in times of anguish and sorrow has offered solace and helped reconcile us to life."

Art helps *me* to be "still attached."

MRI UPDATE

Figure 1

Figure 2

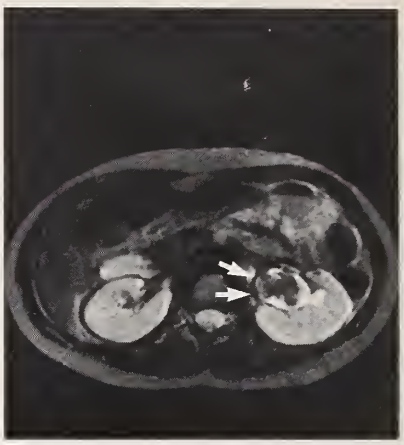

Figure 3

CLINICAL HISTORY: This is a 25-year-old female with complaints of left sided flank pain, nausea, and vomiting.

FINDINGS: Figure 1 represents a coronal T1-weighted image through the kidneys. A lobulated soft tissue mass conforming to the approximate shape of the left renal pelvis and the lower pole collecting system can be identified (large arrow). Signal intensity is intermediate and there is a central area of decreased signal intensity probably representing necrosis. Figure 2 is a sagittal image through the left kidney. In this projection, the soft tissue mass is comma shaped and can be identified extending from the left renal pelvis into the proximal left ureter (small arrows). Figure 3 is a T2-weighted image which exhibits increased signal intensity in the periphery of the mass and central decreased signal intensity. A curvilinear low signal structure lies medial to the mass and is felt to represent the left renal vein displaced by the mass. The vein appears to be patent as evidenced by the low signal intensity indicative of flowing blood (small arrows). No adenopathy is identified. There is no evidence of extension of the mass beyond the margins of the left renal pelvis or the proximal left ureter.

MR IMPRESSION: The location and shape of the soft tissue mass is typical for a transitional cell carcinoma.

MR NOTES: MR of the kidneys is a noninvasive procedure yielding both static and dynamic information about the pathologic process in question. In this case, the MR images defined the presence of the soft tissue mass in the left kidney, the confinement of the soft tissue mass to the left renal collecting system and the proximal left ureter, and the lack of invasion into the kidney and the adjacent pararenal soft tissue structures. In addition, the MR scan demonstrated that there is no evidence of thrombosis of the left renal vein nor is there evidence of tumor into the vein. MR imaging of the kidney is a noninvasive procedure allowing both anatomic identification of renal masses, staging of the extent of those renal masses, and determination of the presence or absence of renal vein involvement for surgical planning.

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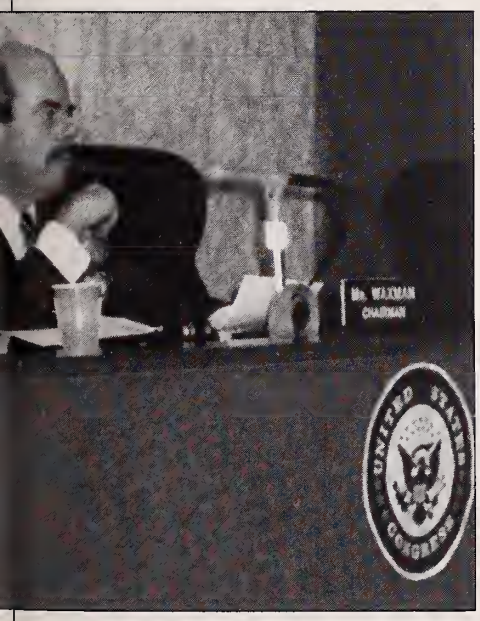
Congress Listens to Georgia Physicians

Cam Taylor



Henry Waxman (D-California) Chairman of the Congressional Subcommittee on Health and the Environment, listened receptively to the testimony of MAG's representatives at the March 5 hearing in Atlanta. He assured those attending that his subcommittee would work to find solutions to relieve Georgians of the burden of Medicare reimbursement problems.

CONGRESS HAS responded to Georgia physicians and patients.

On Monday, March 5, 1990, the Henry Waxman (D-California) Subcommittee on Health and the Environment met in Atlanta to hear about Georgia's Medicare problems. This occurred following months of bitter statewide outcries by physicians against AEtna, the state's Medicare carrier, and HealthCare COMPARE, a profit-making firm that is reviewing claims for AEtna under a pilot program established by HCFA to determine if Medicare outlays could be reduced. Instrumental in arranging the hearing was Georgia Congressman J. Roy Rowland, a member of the subcommittee and Georgia's leading spokesman on the Medicare crisis.

Speaking on behalf of MAG was Joseph P. Bailey, Jr., M.D., who informed the committee that the experimental Georgia Medicare program to "control" costs "Is a proven disaster. The time for experimentation is over. A stable reimbursement review program respected by the Georgia medical community making use of open and clearly stated reimbursement policies consonant with advanced medical technology is now necessary."

Robert B. Copeland, M.D., representing the Georgia Chapter of the American College of Physicians, said the blame should be placed squarely on HealthCare COMPARE. "They have created a system that is so tight, in which everyone is assumed to be crooks, that we are in danger of losing the crown jewel — the sensitive relationship between doctors and patients." These were just a few of the hard hitting remarks made to describe the crisis in Medicare reimbursement in Georgia.

Also appearing were four of Georgia's Congressional representatives: Lindsay Thomas, District 1;

Ms. Taylor is MAG's Director of Medical Practice.

Richard Ray, District 2; Ben Jones, District 4; and George W. (Buddy) Darden, District 7. They testified that the basic problem with the Medicare program was the wide disparity between the promised benefits and the amount of money allocated to the program. They felt there was a "dangerous trend" with regard to access to care.

(L to R): MAG Past President, Joseph P. Bailey, Jr., M.D., of Augusta; Paul L. Shanor, MAG's Executive Director; Robert B. Copeland, M.D., an internist from LaGrange representing the American College of Physicians (ACP); and Deborah M. Prout, Director, Division of Public Policy, ACP, Washington, D.C. Drs. Bailey and Copeland described the problems associated with Medicare reimbursement since AEtna and HealthCare COMPARE took over its administration. These problems have created hardships not only for physicians but for their Medicare patients as well.

Highlights of Dr. Bailey's Remarks

The medical profession in Georgia has demonstrated a long and profound commitment to the elderly patients of our state. In 1989, approximately 8,900 Georgia physicians were enrolled in the Medicare program. These physicians were caring for some 600,000 elderly patients and accepting their Medicare claims on assignment at a rate of 85%. In 1989, Georgia led the country in new doctors signing up as participating physicians.

Voluntary physician acceptance of assignment has continued to increase at an all-time record high, a fact that is clearly indicative of the physician's involvement and concern for their patients' economic circumstances.

Unfortunately, a crisis in Georgia medical standards has begun. Georgia's Medicare Program is at an important juncture where a struggle exists between the physician's ethical and moral responsibilities to provide the best level of medical care needed and the program's efforts to deny that care and payment through administrative obfuscation and review policies. It now appears that Georgia standards are being severely compromised.

HealthCare COMPARE entered the scene with a "meat ax" approach to medical review. Initially, HCFA and HealthCare COMPARE justified this approach by announcing that Georgia doctors were coding for comprehensive visits at a rate 16% higher than the national average. (Later, recognizing that their data were flawed since Georgia coded differently than other states, that it was old data, and that it did not take into account that Georgia has a poorer and sicker elderly population than the national average, this accusation was dropped.)

HealthCare COMPARE suddenly put into place a new set of review policies and screens. Instead of targeting their reviews to the few possible abusers in the system, the entire physician and patient population was virtually assaulted. Yet, while having to admit that they had misled the public about Georgia doctor's practices, the "meat ax" approach to redoing costs continued unabated.

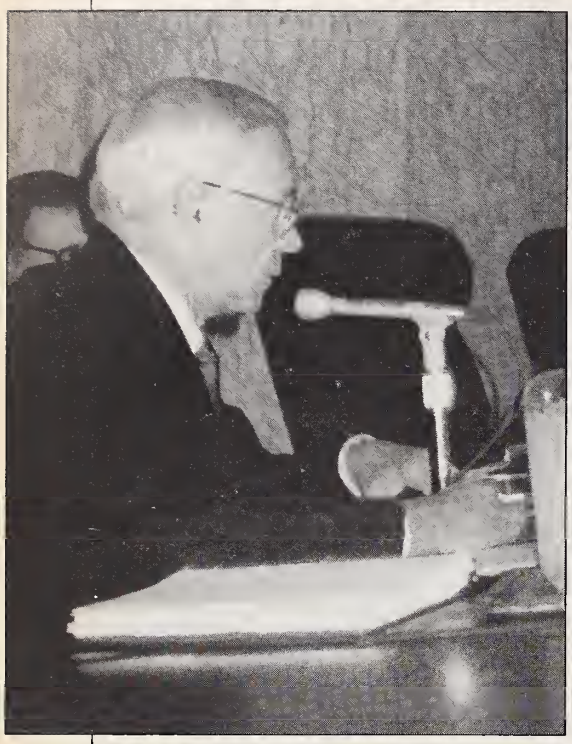
Policy blunders occurred in comprehensive office and hospital patient services, concurrent care, and medical consultations as have been uncovered in the MAG survey of services conducted in June and July of 1989. The major thrust of the HealthCare COMPARE effort, however, appeared to be deliberate and could not be attributed to inadvertent reductions of service. The reductions were across the board, of all comprehensive and extended level medical services in outpatient, hospital, and nursing home settings for the elderly patients in Georgia. But of even greater importance, is the effect the policy changes have had on the patients themselves and on the level of confidence and trust in their physician. For every inappropriate policy established, hundreds or even thousands of letters advised the patients they had received a "medically unnecessary" service. In many instances, further implications were

made that patients originally were overcharged for care and that physicians would need to reimburse the patients. These events have resulted in tremendous misunderstanding and significant distrust.

Mr. Chairman, I suggest we take the opportunity provided in this hearing and in this new decade to reconsider the reimbursement and utilization framework for the elderly patients in Georgia. We believe that a number of immediate actions should be considered:

- Termination of the formal contract arrangements with the HealthCare COMPARE Corporation of Chicago.
- Development of a new, simple-language Utilization Review instruction set that enables physicians to know and track changes in medical review policies for approvable services to the elderly. This includes computer screens in use for actual reimbursement decisions.
- Engagement of an outside consultant management team to assist in streamlining the administrative operation of the claims processing in light of pending legislative reform; more specifically the use of the RBRVS for reimbursement.
- Launching of a public relations effort between the Medicare carrier and Medicare recipients and the physician community to re-establish mutual physician-patient trust concerning reimbursement decisions.
- Completion of claims adjustments to adequately compensate for financial loss and provision of adequate explanation to the patient in case of misapplication of policies.
- Amendment of the Medicare law offered by Senator Howell Heflin of Alabama that would allow the attending physician to bill for Medicare even when coverage is provided by a covering physician. As Doctor and Congressman Rowland knows, such billing procedure provides that payment flows with responsibility, and provides for less patient confusion. Over 43 states currently bill Medicare in this manner, and Senator Heflin's amendment would simply recognize current practice. (See *Congressional Record,* Vol. 136, No. 7, Feb. 1, 1990.)
- Introduction of language in Section 1869 of the Social Security Act to provide that persons providing services to Medicare patients may have a legal remedy in the patient's or their own name when the carrier fails to abide by the law or HCFA's regulations, rules, or policies.
- Regulation of utilization review agencies. There are at present no standards for either the companies or their reviewers. The insurance companies are regulated, the physicians are regulated, but there are no state or federal standards for UR companies. They can claim to hire physicians, but there are no standards to require that those hired have ever practiced, or if they have ever had their license revoked or suspended. We also have no standards showing that the reviewers are not impaired from drug or alcohol abuse, or that they are not felons. Some minimal standards should apply to insure that the reviewers recognize good, competent medicine when they see it.
- When a large number of denials occurs and is caused by a single policy and affects several physicians, the physicians should be able to appeal in a group and be represented by their state medical society or association.
- Extend physician time frames for "participation decisions" by the same amount of time granted to the AEtna carrier.

Four of Georgia's Congressional representatives spoke about the wide disparity between the promised benefits and the amount of money allocated to the Medicare program. Shown here L to R are: Lindsay Thomas, District 1; Richard Ray, District 2; Ben Jones, District 4; and George (Buddy) Darden, District 7.



Georgia Congressman J. Roy Rowland, a member of the Waxman subcommittee and Georgia's leading spokesman on the Medicare crisis, was instrumental in arranging this hearing.

The Medical Association of Georgia is committed to working with the Medicare system to provide the quality and appropriateness of medical care needed for its elderly citizens. The State of Georgia has a very large and growing Medicare population that often requires a higher intensity of treatment than the rest of the population. Many times this requires an expensive service. We believe that an administratively sound and efficiently run Medicare program is the best vehicle to make these distinctions.

Highlights of Dr. Copeland's Remarks

The American College of Physicians (ACP) believes that the events in Georgia are illustrative of the critical need to continue the reform efforts begun by this committee in its work on physician payment. On a larger national scale, events in Georgia are a compelling reminder of the need for: reforming our utilization control methods and procedures; moving ahead with reform of the coding system; and addressing the serious problem of administrative costs in our present health care system and the attendant administrative burdens felt by patients and their physicians.

We urge Congressional scrutiny of the protocol for the Georgia pilot project . . . and the circumstances surrounding the awarding of a contract to HealthCare COMPARE. We are deeply troubled that this subcontract appears to have been renewed at the end of the initial year without discussion or evaluation and in the face of continuing serious problems in the carrying out of the review functions.

Consequently, the situation in Georgia raises profound questions about whether appropriate safeguards exist in the system to assure that utilization review efforts do not become a tool for wholesale cost containment and budget savings exercises as opposed to their proper role in assuring that appropriate services are delivered to beneficiaries.

Additionally, we believe that as we look towards reform of our health care system, we must examine the role of for-profit enterprises in review and other activities and ask serious questions about the inherent conflicts that may well exist for such enterprises.

In short, there are a host of issues raised by the situation in Georgia that relate to: (1) rectifying problems and ensuring appropriate behavior and sufficient accountability on the part of HCFA, AEtna, and HealthCare COMPARE in the immediate future; (2) the implications of the AEtna/HealthCare COMPARE pilot project, its protocol, and how it will and should be evaluated; and (3) ongoing and urgently needed longer-term reform of the health care system throughout the country.

However, even today, long after admissions from HealthCare COMPARE that mistakes had been made in the screens that were applied to comprehensive visits throughout a significant portion of 1989, there is no adequate mechanism for redress on behalf of those individuals who provided services that were inappropriately downcoded. Despite assurances from Dr. Robert Becker in November that claims denied or downcoded as a result of inaccuracies in HealthCare COMPARE's operational definition of comprehensive services would be identified by computer and adjusted, we have subsequently been informed by HCFA that each such claim must be individually appealed by the physician. This represents a virtually impossible procedural task for practicing physicians, and its impossibility will allow HCFA, AEtna, and HealthCare COMPARE to claim significant cost savings in the Medicare program.

Data presented by HCFA indicates that between January and June, 1989, 22.8% of "comprehensive services" delivered by internal medicine were suspended for review; 82.1% of these were then reduced at an average reduction per service of $35.82. This achieved a budgetary savings of $960,571 during a 6-month period for internal medicine alone. For all specialties combined, the savings was $1,945,505 during the 6-month period. Now we have a direct admission that certain of these decisions were in error, but no realistic hope of recovering funds inappropriately denied.

The increasing administrative burdens of practicing medicine in 1990 are also contributing to the difficulty that we are experiencing in Georgia and elsewhere in recruiting new physicians into primary care medicine. The consequences of these practical effects are particularly troubling in view of statistics indicating that 29% of physicians are 55 years of age and older. We may face a time when despite our national policy goals there are not sufficient primary care practitioners to care for the Medicare population.

There also appear to be serious technical errors in the Maximum Allowable Actual Charge (MAAC) levels for selected services, in particular for extended and intermediate visits. For many physicians this means that these levels of service are paid at rates substantially below comprehensive visits, totally out of line with previous practices. To date, HealthCare COMPARE and AEtna have indicated that achieving corrections and adjustments in payment levels that do not comport with even common sense analysis of reasonableness is a problem that the medical community must resolve with HCFA. We view this as a lack of corporate commitment to creating a payment system that functions fairly and effectively.

The experiences in Georgia point to the need for short-term and long-term reforms. First, there must be mechanisms to assure appropriate responsiveness to questions and concerns raised by the physician community. In Georgia, profound disagreements with respect to the clinical and analytical bases for reviewer's practices have been allowed to remain unresolved for 14 months. Meanwhile, it becomes increasingly difficult for physicians to deliver primary care services as their time is spent responding to documentation and paperwork demands and preparing appeals on services denied or downcoded. Patients lives are made more difficult in the confusion over changing rules, denied claims, and altered payment levels.

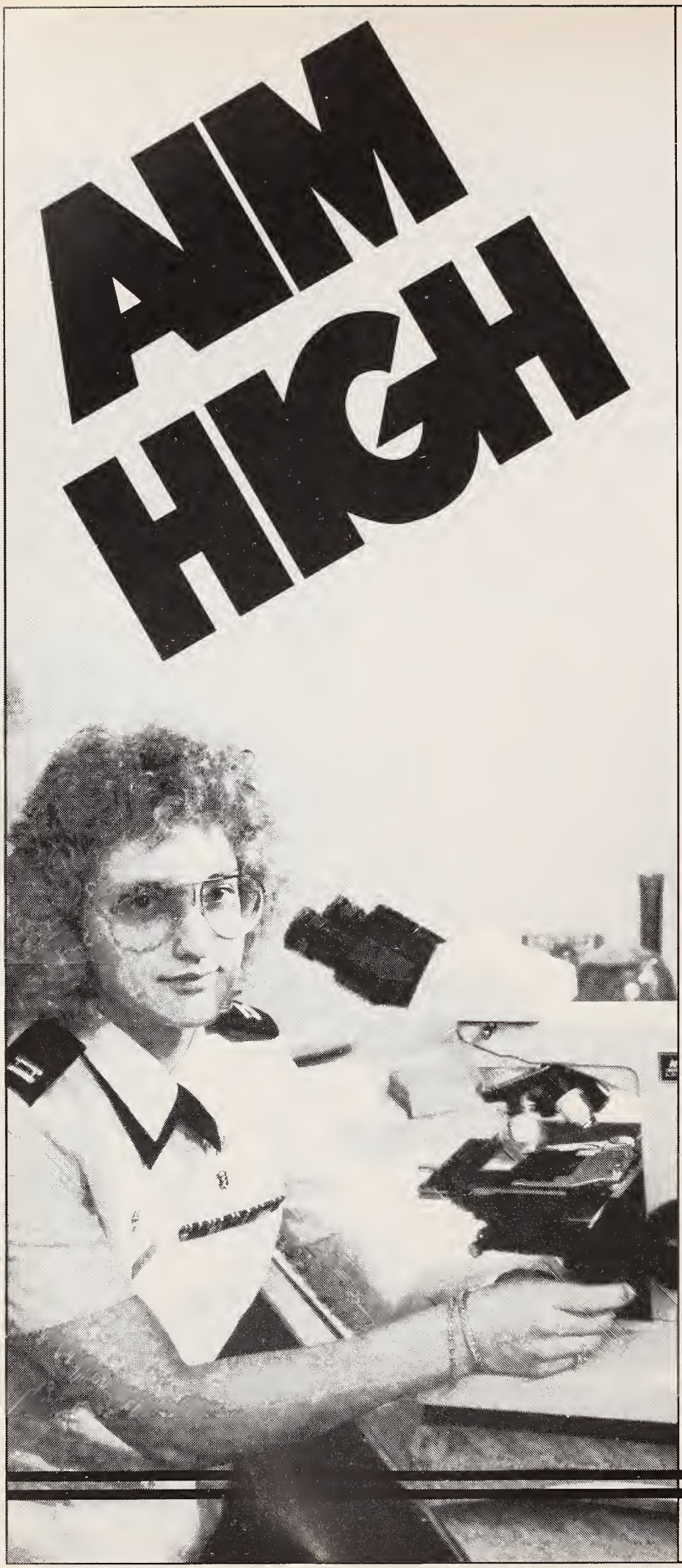
As we have testified before this committee before, major reform is needed in our approach to utilization review. At present, such review operates in a punitive fashion that frequently treats physicians as crooks and patient-physician encounters as fraudulent until proven otherwise. Recent hyperbolic statements in the Georgia press by HCFA and others that imply wholesale abuse and fraud in the system have not contributed to a positive climate. The failures in the approach taken so far in Georgia underscore the need for a fundamentally different approach and attitude towards monitoring service delivery in the future.

We would urge a series of immediate, short-term remedies for the specific situation in Georgia. We urge Congressional scrutiny of the protocol for the Georgia pilot project, the criteria under which it will be evaluated, and the circumstances surrounding the awarding of a contract to HealthCare COMPARE. We are deeply troubled that this subcontract appears to have been renewed at the end of the initial year without discussion or evaluation and in the face of continuing serious problems in the carrying out of the review functions.

The major thrust of the HealthCare COMPARE effort appeared to be deliberate and could not be attributed to inadvertent reductions of service. The reductions were across the board of all comprehensive and extended level medical services. . . .

We would urge that steps be taken to ensure that contract performance standards and performance standards for carriers better recognize the need for meaningful and appropriate liaison with the physician community. At present, carriers appear to be free to ignore the need for appropriate liaison and responsiveness. This fosters the view among many physicians that the primary role of utilization review is cost control not assuring appropriateness.

Following from this, we would challenge recent policy changes of the Health Care Financing Administration to now prohibit the release of information on the screens used for performing reviews of services. We believe that this inappropriately eliminates useful discussion of the clinical basis for such screens and undercuts physician confidence in the correctness of the review process. We are not convinced such screens are purely a management tool unrelated to clinical appropriateness. We hope that you will examine this issue. ■



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A Message and a Challenge

Congressman Newt Gingrich

On February 3, 1990, 6th District Congressman Newt Gingrich gave the keynote address at the Medical Association of Georgia's 1990 Leadership Conference held in Atlanta. Due to the impact of that message on those in attendance, a synopsis is provided here.

Doctors, as a group, are to politics remarkably like the patient who is overweight, smokes, doesn't exercise, drinks a quart of liquor daily, and shows up in your office every other year and asks you to make him well.

I appreciate the chance to be here, and I take seriously the idea of giving the keynote address. I want to cover a framework of thoughts in a very bold way, and then give us time for questions and answers. I'm going to rapidly walk you through an outline of ideas, and I will welcome those of you who get real excited to get a copy of the book I co-authored with my wife, *Window of Opportunity*.

I basically have three themes. The first is that doctors, as a group, are to politics remarkably like the patient who is overweight, smokes, doesn't exercise, drinks a quart of liquor daily, and shows up in your office every other year and asks you to make him well. You would say to that patient, "You are engaged in a set of habits that make it impossible to meet your request." And I say to all of you, given the scale of challenge you're faced with, unless you are prepared to undergo a systematic rethinking of how you function, you are not going to win the fight.

Congressman Gingrich

Second, it is my judgement that the tactical skirmishes you are embroiled with — accident insurance, health care, administration, malpractice insurance fights, Medicare — cannot be won at the level you're fighting them. You are just going to keep getting ground down. If you were to draw a big chart and look at doctor return per hour invested, relative happiness at the job, amount of power and control over your life during the last 35 years, the chart would show a significant decline. Doctoring isn't as much fun as it used to be. While you have greater technical power, you have

much less real control over what you are doing. You are more linked with the larger world, which has some dramatic misunderstandings about you.

My third point is that, from a national standpoint, it is impossible to solve the health care problems of the United States within the current model. So as a history teacher and a politician, my message is that it is your responsibility, and in your self-interest, to help us invent a different approach to health care. This requires thinking differently than you're used to thinking.

Some of you may say I'm only going to expend "X" amount of effort, and give "Y" amount of money. Let me remind you that is precisely the kind of response you get when you sit down with that 52-year-old patient I referred to earlier. You say to them, "You're 70 pounds overweight. You're smoking two packs a day. You're drinking too much, and you are in fact, a time bomb waiting to explode."

So, as a professional in the field of self-government, I say to you that there is a core of principles in this process just as there is in health care. Just as you have sets of frameworks you start learning in medical school, there are learnable patterns in the art of self-government. And if you intend to be effective in that business, you have to learn those at least up to the level of being a serious amateur. You have to learn at least as much as you would want a patient to learn about a complicated health problem that necessitated their having to change their behavior.

Now let me also suggest that George Bush is giving you an enormous opportunity. If we respond to his announcement about Louis Sullivan the other night with real nerve and real courage, it could be very exciting. But if it's dealt with the way things normally are in Washington, some will gather in the usual gang of experts, sit around the usual table, and come up with the usual dribble. But there's an opening here to say, why don't we have five or more teams and develop for Dr. Sullivan a wide range of options based upon very different paradigms. Then have a national debate about the kind of health care we need for the 21st century.

From a national standpoint, it is impossible to solve the health care problems of the United States within the current model. . . . It is your responsibility, and in your self-interest, to help us invent a different approach to health care. This requires thinking differently than you're used to thinking.

Rather than try to find the one best solution, which I suggest is not possible at one time, what if we were to look at five or six very different patterns? What if we then come back to the country and say, would you rather be in this kind of health care system, or this kind, or this kind? You can do this, I think, by dramatically expanding the universe of people who are playing in the health care business in terms of Washington policy, and by breaking out of the usual patterns to create a new framework. Let me describe in a little bit of detail what I mean by that.

First, I think you have to back off from everything you currently know. You back off in the sense that when you talk about the concept of a paradigm, you argue that what happens is. When the old paradigm begins to get boundary problems it can't solve, the experts come up with more and more complicated anecdotes to explain the paradigm. It gets more and more encumbered, and finally it just doesn't work anymore. But this paradigm is the only thing you know; it has to work. So you hide the fact that it doesn't work, and you add mounds of appendices and amendments to the core paradigm.

Then somebody comes along, and they have a new breakthrough. They conceptually think it through a new framework. And a standard response of all the existing experts is to deny the new solution. You spend your lifetime learning the old paradigm, all of its pieces. You have so much invested in it that letting go is an enormous disinvestment. All of your underlying patterns are involved in what most of you understand as common existence.

You have so much invested in the old belief that, even if it's crazy, you stick to it because the new belief is too expensive. Even Einstein could not win the prize for his real breakthrough in relativity because it was too radical and the senior guys didn't believe it. Eventually, however, the senior guys die out. What usually happens is the younger generation comes along, and they are given two choices. They can accept the old order, in which they have no investment, or they can accept this more elegant new order. They promptly shift to the latter. It makes more sense if you don't already have an investment in the old.

If you work on a planning model, there are four key words: vision, strategies, project, and tactics. Vision, at the top of the hierarchy, is what you generally think you're doing. Strategies, which is plural, is second because no vision could be without strategies. Projects are roles you can delegate to some-

Many physicians have told me that they felt bound by the teachings of the medical schools. . . . If they need to be changed, form alumni associations for intelligent medical education. Don't give money to the alumni fund, set up a separate fund for innovation and change.

body else to be carried out. Tactics is what you do every day. Over 90% of all lobbying and contributions are tactical.

Remember, I come at this from a background as a conservative who helped found the Military Reform Caucus because we started with the premise that the Pentagon was simply a normal bureaucracy. Large bureaucracies tend to behave in ways that are dumb. Bureaucracies are prepared to bring the same level of expertise to the red tape and dumbness to the playing fields that the Pentagon does. HCFA is basically being run by bureaucrats who don't like doctors, which is a little bit like running the Pentagon with people who don't like the military.

For those of you who might decide this is a purely theoretical speech, remember I am the Republican Whip. I do vote counts every week. I am very prepared to play tactical games. I win congressional races. And I understand that you have to open up your office door every Monday, and you have to pay your malpractice insurance. So I'm not being theoretical. I am saying you're at a point in time where the most rational investment is to develop a new model, create a new vision, and create new strategies. In that framework, I want to suggest a couple of principles for you to think about.

The first is that there is a triangle of success. As a former professor, I urge you to draw out this triangle so you'll be able to look at it later. One side of the triangle is basic American values, things that would be valued if you read any set of biographies in the last 300 years — hard work, savings, studying, investing, risk-taking — values that recur universally in America.

The second side of the triangle is technologic progress. Why do Americans live better? Because in the past 100 years we have had an enormous investment in inventing new technology. And until 20 years ago, we were the least resistant culture on the planet. Therefore, the new could crowd out the old because there was very little in the way to stop it. The third side is entrepreneurial free enterprise. This is as much a cultural act as the Smithsonian or Jonas Salk. It is a way of thinking; a way of getting up in the morning. That's why we like football and quarterbacks. We like the idea of people who get out there on the field and take risks.

The alternative value structure to this triangle is the bureaucratic welfare state, combined with the values of the left, described in R. Winston Collier's *Destructive Generation;* Paul Johnson's *Modern Times;* and Fernando DeSoto's *The Other Path.* While DeSoto's description of a bureaucratic, lawyer-dominated culture is a depiction of Lima, it also describes Atlanta, New York, Philadelphia, and Washington. Those books give you a framework of intellectual thought that I can summarize very simply.

Look at glasnost and perestroika; look at the changes in Eastern Europe. Our command bureaucracy is not dramatically different than the Polish bureaucracy. HCFA is not dramatically different than the Hungarian bureaucracy. When you have a command bureaucracy, you invariably have the structure of intellectual thought developed around 1870. Now that is a pre-computer, pre-typewriter society in which male clerks pushed quill pens. That's the core model whether it's a school board, the Pentagon or state government. It's a way of organizing information flow and human activities that is about 120 years out of date. It cripples the whole western culture. It creates a wedge of inefficiency and distortion which limits our capacity to produce prosperity.

Rather than try to find the one best solution, which I suggest is not possible at one time, what if we were to look at five or six very different patterns?

One of the reasons we decided to invent a triangle was to make the argument that we have to quit trying to find one correct solution. Instead, we have to liberate the American people and American institutions. Any idea inside the triangle is probably better than the current bureaucratic welfare state and the values of the left. Almost any experiment is worth trying compared to the current structure. This means you have to have a mistake-permissive and an error-permissive system.

Remember that in Michigan, just before Henry Ford, there were 400 auto companies. There was no presidential commission to figure out which one company to start. So if you want to go back to a world where you can experiment, you won't get there by having national commissions that produce one good idea. First of all one good idea,

at the national level, will always be too conservative, too rigid. It doesn't think through the real world in which that nice big idea turns into 27 small problems. It's the solving of the 27 small problems, using the entrepreneurial system, that's so powerful.

Just as you have sets of frameworks you start learning in medical school, there are learnable patterns in the art of self-government. You have to learn at least as much as you would want a patient to learn about a complicated health problem that necessitated their having to change their behavior.

One of the models I want to give you is the nine-dot problem. Put down three dots in a row. Directly under those dots, put two more rows of three dots, so you end up with nine dots. There is a technique by which you can draw four straight lines and cover all nine dots. You can cross the line, but you can't lift your pencil. The secret is you have to go beyond the boundaries of the nine dots. Go up a straight line through the middle, take the three on either side, and go down as if a fourth dot were present. Then go across the diagonal as if a fourth dot were present.

The point is that there are no boundaries. Dots are by definition non-bound, they're points in space. The problem is that about 95% of all people bring to problems their own boundaries. They identify the reasons they can't. Let me give you this premise. My name is Newt Gingrich, I have no army record, I have no family base, no money. I speak with a strange accent, I am a college professor, and a Republican. It is 1974, in the middle of Watergate. Now somewhere in that list I could have told you why I would not be standing here today as the Republican Whip. Instead, what I said was I'm free, I like the game, I've got the guts to run.

Many physicians have told me that they felt bound by the teachings of the medical schools, by legislation, by the legal system, and by the expectations of the public. All of you are alumni of various medical schools. If they need to be changed, form alumni associations for intelligent medical education. Don't give money to the alumni fund, set up a separate fund for innovation and change. Do whatever you have to do. All of you have the capacity to run for office, or have a relative or close friend who can run for office. If your local legislator isn't listening to you, find somebody else.

Rotate who goes on radio talk shows. We have to have a legal system, and we need lawyers. But a substantial number of lawyers are not trial lawyers. A number of attorneys would be eager to ally themselves with a medical professional who was serious about change. So you and your lawyer go on local radio and simply defeat the arguments. You're not defenseless.

Educate the public as they walk through your door, as they sit in your waiting room. Somebody ought to design the ideal waiting room to transform American thinking. Start thinking about what kinds of cartoons should be playing for kids that explain what a good health care system would be like. Does all this mean you have to be smart? Yeah, it took me 5 years of straight campaigning to become Congressman.

HCFA is basically being run by bureaucrats who don't like doctors, which is a little bit like running the Pentagon with people who don't like the military.

Let me give you a true story. I was at the 82nd Airborne at Fort Bragg talking to the guys who had gone to Panama. When they were assigned to Panama, they knew the best weapon would be 50 caliber machine guns from World War II, which were sitting in the warehouse. But, they had a problem. The vehicle they use, an HUMMV, is not designed to carry a 50 caliber machine gun. So, in violation of all Defense Department procurement regulations, they went out and bought cast iron, took it to their maintenance shop, cut it up, did some welding, and had a perfect unit to be pulled inside the HUMMV.

They had one more problem. The army safety check for these weapons takes 14 months. So the Lieutenant General personally took all the machine guns down to the range, and fired them off. For the ones that worked, which was all of them, he personally signed the slip certifying their safety. It turned out to be the best single weapon system in Panama. What the Lieutenant General did was clearly against the rules. He probably reasoned that the bureaucracy has invented a series of values that don't exist if you're serious. So he broke rules on behalf of saving American lives.

Now, one of the radical ideas we are suggesting is that you ought to be designing the system. The genius of the American tradition was that we used to have a system designed around human nature which

encouraged intelligent behavior. Over the last 35 years we've replaced that structure with a system that actively punishes common sense. I will give you a simple test. Walk into any government system on any level, come up with five common sense ideas, and at least four of them will be against the rules. That's stupid. There is no reason to cripple ourselves as a nation, and then try to play with the Japanese and German structure.

To wrap up, I'm going to give you some specific, thought-provoking ideas for applying these general principles. They start with the notion that you want to develop a change-oriented style. You want to focus on how you are going to change tomorrow morning, rather than on how to avoid risk. On May 19 we are going to air by satellite a 90 minute program called AN AMERICAN OPPORTUNITY WORKSHOP. We are going to make it available to any Democrat, Republican, or non-voter who is interested in the idea that applying common sense focused on success may be better than the bureaucratic welfare state.

We're going to try to create this model of thought and find specific examples where it is already working, because you've got to enhance the energy level of people by showing them success. Any hospital, doctor's office, home, or hotel that has a dial link can participate. And if they decide they want to organize a workshop, we'll give them a leader's workbook and an activist workbook. They are then free to make as many copies of each as they need.

One of the problems of the last 35 years has been a passion for failure in America. We know far more about the pathology in the inner cities than we know about the young people who have successfully risen above it. And part of that is, frankly, a problem with the news media. When Edison invented the electric light, it was not recorded with a headline that said, "Ralph Nader warned today that people would die if electrocution if lights were put in their homes." There was an accurate report on the electric light and the idea that this was a major breakthrough. But we now have a mind set, in our academic, political, and news communities that focuses on problems in a way that is dysfunctional if you have a technologically progressive society.

Now let met give you some quick examples of how I would tend to think if I were a doctor. First of all, I would recognize the need for a lot of people who are playing games. Almost in the sense of war games we need health games, because you need to take your neat idea and then get people to role play. If we abolished HCFA in the morning, who would be responsible for making sure that people are honest? Who would be responsible for making sure that costs were accurate? There have to be gatekeepers. So once you have an idea, you have to role play it out to see what would really happen.

Even Einstein could not win the prize for his real breakthrough in relativity because it was too radical and the senior guys didn't believe it. Eventually, however, the senior guys die out.

Second, you ought to consider a tax credit for caring for the poor. Swap the current Medicaid system for a tax credit. Guarantee that anybody who is poor can walk in, and we'll take care of them. We'll keep the same medical records we have for the insurance companies, and be audited by the tax side rather than by the specific Medicaid plan.

There's an opportunity here to say, why don't we have five or more teams and develop for Dr. Louis Sullivan a wide range of options based upon very different paradigms. Then have a national debate about the kind of health care we need for the 21st century.

Now you ought to consider a malpractice cost cut. The AMA should go to Dick Darman and say, "If you will pass a national malpractice law that goes for its bad outcomes, rather than the current lawyer-dominated insanity, we will lower the total cost of health care provided by doctors by 'X' amount." The average citizen is dramatically rational. They tend to go to a doctor they think will probably not engage in malpractice. They seldom say, "Let me find the guy who has been successfully sued 40 times because I want to be rich right after he is done with me." So if given the choice of unlimited coverage at current charges or limited coverage at reduced charges, the majority would choose the latter system.

I would also suggest you invent user friendly technology. One of your greatest of the many challenges you have is to impact as much of your knowledge as possible to the patient. My guess that is you would be stunned if you really looked at the procedures you're engaged in that could be self-administered if you worked at it. If you consciously tried, we could get the cost down by getting all the trivia out of the system.

I also suggest that you look at problems like inner city health care. We are going to have to go to dramatically greater use of paramedics and nurses. Everybody in health care collectively has failed to solve the problem in Chicago or downtown Atlanta or New York City. It is a disgrace that we have prenatal care at the level we have today. There is no excuse for it. So we need some people who say, "All right, this is not a direct threat to fee for payment. This is not a direct threat to my professionalism."

We're going to have zones in America that aren't going to have enough doctors in the next 5 years, and we have got to figure out, much as we would in a war or a national emergency, what is the common sense solution. Then, we have to do it. I'll tell you what I say to every conservative audience in this country. If we are going to care that a 9-year-old girl in the ghetto says the Pledge of Allegiance, then we have a moral obligation to care about the rest of her day, the rest of her week, and the rest of her life.

If you apply that test to health care in the inner city today, it is a national disgrace that everyone of us should be ashamed to tolerate. But we can solve this in 3 to 4 years by simply closing down the bureaucracy and creating a new model that works. That may mean that every big public housing project gets its own medical center. The medical center is deliberately inexpensive, and it's electronically wired to the nearest hospital. And it uses people who are relatively inexpensive, but adequately trained. The urban poor should get at least adequate health care, and you can invent the adequate if you'll go outside the nine dots.

The AMA would have a substantial impact if you came out with an individual health savings account, if you said that people ought to be allowed to save "X" amount every year with a tax credit, and "Y" amount with a tax deduction. At the age of 65, they could turn it into an IRA. You find new ways to create positive incentives so the deductible on their insurance is not a big deal. As you go through a series of these steps, you re-establish the consumer of medical services as the gatekeeper.

One of the problems of the last 35 years has been a passion for failure in America. We know far more about the pathology in the inner cities than we know about the young people who have successfully risen above it. And part of that is, frankly, a problem with the news media.

In addition, maybe we ought to tell people that if you get an annual physical and all of your cardiovascular numbers are right, the entire physical is a tax credit. Maybe we ought to say to people over 65 that if your doctor certifies that you are keeping the risk of heart attack below a certain level, we'll give you a $500 bonus, because it's cheaper than taking care of you. I'm not arguing this directly yet, but I am suggesting that if we reward a person for being less likely to show up on the medical chart, people will begin to say, "I really should be doing that," because there is money involved.

I'm doing this in education, by the way. This summer I'm going to take some of my speech-making money and pay third graders in public housing $2 a book to read. We're going to say to them, "You want a bicycle, read six books. Come in once a week, get an adult to check that you read the book, and here's your two bucks." If you reward the behavior you want, it is stunning how fast Americans learn. Andy Young is right. There is no culture on the planet that has a common color like America, and the color is green. We just have to think in new and different ways.

Let me also say in terms of your profession, more than any other profession I know of, politics has to acquire primacy at the core of how you think for at least the next decade. You're among the brightest people in America, but you don't spend much time learning the skills of making sure that human beings understand what ought to happen.

National health care is going to come; you can't avoid it. In addition to Medicare and Medicaid, look at the pressure among the business community. They decided that since their health care costs are high in a free market environment, they'll give these costs to Teddy Kennedy in return for a tax increase. I think this is probably the dumbest strategic move American business has made in a long time. It would result in a politician-dominated system in which their taxes would go up as would the government's control over our lives and over the health care system.

The doctors in my district tell me they're drowning in red tape. They say the power is shifting away from medicine, toward bureaucracy. They say the future for health care in America is potentially very destructive of the values they hold dearest. They think substantial change is needed to get to the kind of health care systems they want to have, where they can have the freedom and the opportunity to provide

the kind of care they think the American citizen ought to have.

If the doctors in this country will learn politics 20% as well as they learn medicine, you would create over the next 10 years a health care system which would be a lot more fun than the current structure. You would be relatively wealthier, and lawyers would be relatively poorer. People would have a wider range of choices, and more health care decisions would be made by people who knew something about health care. Just that would be worth the investment. And if you're not willing to make that investment, who do you think will?

This country has been very to good to every one of you. This country has given you freedom. It has given you a chance to earn a very good living. It has given you a chance to play technical games you want to play. But very few of you reinvest in your country. What you say is simple. You say, "Hey, I take care of patients; and I'm busy. I'm tired at the end of the day, and the political system ought to just work. Why is it picking on me?" And my answer to that is "Baloney."

This isn't George Bush's country. It isn't Newt Gingrich's country. It isn't Billy Lovette's country. Each one of you has an obligation to be involved precisely to the degree you think you can either improve your children's future or avoid disaster. In this country, every person brushes the teeth of the human being who is morally responsible for the future of the United States. I thank you very much.

When the old paradigm begins to get boundary problems it can't solve, the experts come up with more and more complicated anecdotes to explain the paradigm. It gets more and more encumbered, and finally it just doesn't work anymore.

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Ciguatera

Andrew E.B. Swift, Thomas R. Swift, M.D.

Despite native cures derived from the leaves of a certain plant in New Caledonia and from attempts to identify tainted fish, no methods of prevention or detection have been proven effective. An enzyme immunoassay stick test has been developed but is not readily available.

Introduction

"When I was 17, my father and I went fishing off Alligator Light in Islamorada in the Florida Keys. My father caught a 25-pound barracuda which we gave to the maintenance man at the motel where we were staying. That night the man and his family cooked and ate the fish. During the night he, his wife, and their three children all became so ill that the entire family had to be admitted to a hospital, and one of the children almost died. Although I didn't realize it at the time, this was my first experience with ciguatera." TRS

CIGUATERA POISONING is the most prevalent form of marine food poisoning in the world today. Less common are puffer fish poisoning due to tetrodotoxin and scombroid fish poisoning due to spoiled tuna and related fish. Ciguatera is a major cause of morbidity in the Caribbean and South Pacific, with an annual incidence between 100 and 300 per 100,000 population. First documented as early as 1457, the name comes from the word "sigua," which refers to the snail *Turbo pica* found in the Spanish Antilles, which may contain a similar toxin.[1]

The edible fish responsible for ciguatera poisoning harbor minute quantities of toxins passed through the food chain. Because they have lived longer, and therefore store more toxin, large fish are primarily responsible.[2] The toxins are produced by *Gambierdiscus toxicus*, a marine dinoflagellate 75 microns in diameter, which lives in tropical and sub-tropical waters on the detritus layer of red and brown coral.[3] (Figure 1) Because of certain unique features, this organism has been placed in its own family, *Heteraulcacae*.[4]

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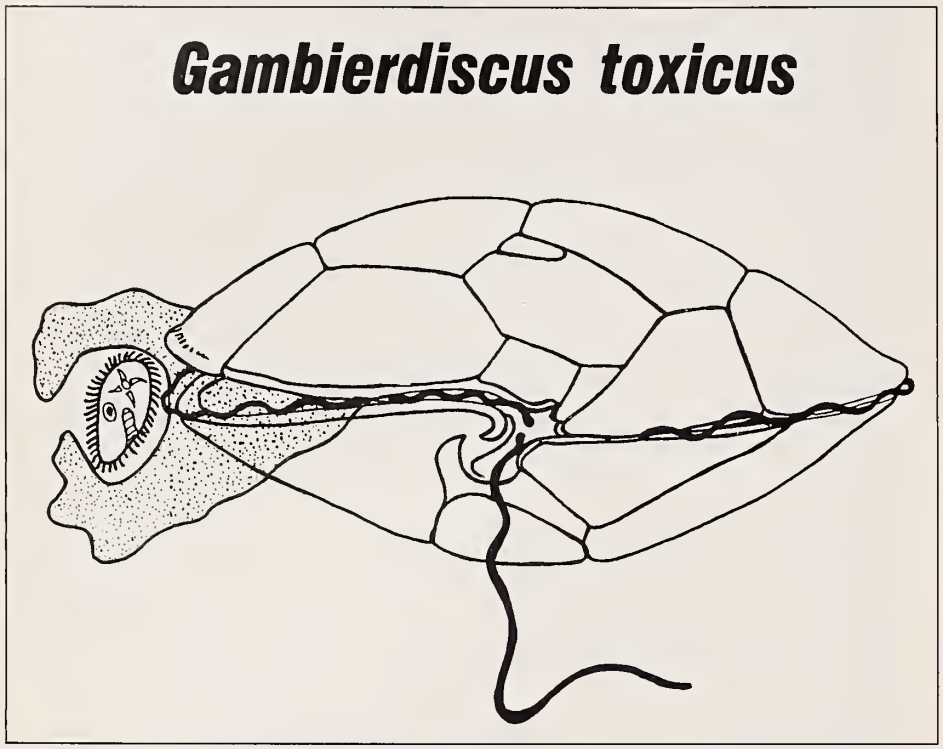

Figure 1. The dinoflagellate responsible for Ciguatera, Gambierdiscus toxicus, *ingesting a paramecium.*

Toxicology

Ciguatera poisoning was once thought to be the result of a single toxin. However, *G. toxicus* is now believed to carry a number of toxins, although only three have been identified.[5]

Historically, the toxins have been difficult to obtain because of problems recovering toxin from the cultured dinoflagellate and extracting it from carrier fish. In one study, 1000 kilograms of toxic fish yielded only one microgram of purified ciguatoxin.[1]

There are both gastrointestinal and neurologic manifestations of ciguatera intoxication in man. Although some have speculated that ciguatoxin causes predominantly gastrointestinal problems and maitotoxin causes only delayed neurologic problems, this remains unproven.[6] Despite native cures derived from the leaves of a certain plant *(Duboisia myoporoides)* found in New Caledonia[7] and from attempts to identify tainted fish, such as the rejection of toxic fish by an ant or the ability of toxic fish to turn a coin black,[2] no methods of prevention or detection have been proven effective. Prevention of ciguatera is clearly needed. To that end, a simple, economical procedure is needed to identify suspect fish before they are brought to market. An enzyme immunoassay stick test has been developed and is being evaluated, but is not as yet readily available.[8]

The first fish to harbor the toxin are the microphagous or grazing fish which, when eaten by carnivorous fish, pass the toxin up the food chain to man.[1] Both herbivorous and carnivorous fish have been implicated in ciguatera outbreaks. Some fish in tropical and subtropical areas are so commonly toxic that their sale has been banned (e.g., the barracuda in southeast Florida).[9, 10] Some of the other most commonly toxic fish include red snapper, amberjack, and king mackerel (Figure 2), but any reef or semipelagic fish may be potentially toxic.[1] The gonads and liver have much higher concentrations of toxin than the flesh and should be avoided.[1] Ciguatera poisoning is usually limited to fish caught between 35 degrees N and 35 degrees S and is endemic in the Caribbean and southern Pacific Ocean. The percentage of fish harboring the toxin may demonstrate seasonal fluctuation,[9] but paradoxically some fish in captivity have been shown to maintain high toxicity for long periods of time.[1]

Epidemiology

Ciguatera's notoriety came about in the 1960s and 1970s as its painful and chronic symptoms reached epidemic proportions in the South Pacific. It was noted that there was a correlation between an increased incidence of ciguatera and increased military activity—activity which involved tremendous reef damage as a result of construction and nuclear detonation.[11] An increase in ciguatera is also seen following natural disasters such as storms, earthquakes, tidal waves, and heavy rains which disturb the ecology of the coral reefs.

During and after World War II, several governments moved into the South Pacific for both strategic military locations and to test nuclear devices. As the construction began, building materials were dredged and blasted from the nearby coral reefs. Nuclear devices were also detonated, and although radiation has shown no appreciable effect on *G. toxicus*, the blast undoubtedly caused tremendous reef damage. The corresponding rise of ciguatera poisoning in response to military activities in French Polynesia was virtually linear, from less than 20 cases in 1960 to over 1400 cases in 1972.[11]

Another example of a reef disturbance-related outbreak occurred on the atoll of Hao in French Polynesia. In 1963, construction began for a military base and airstrip.

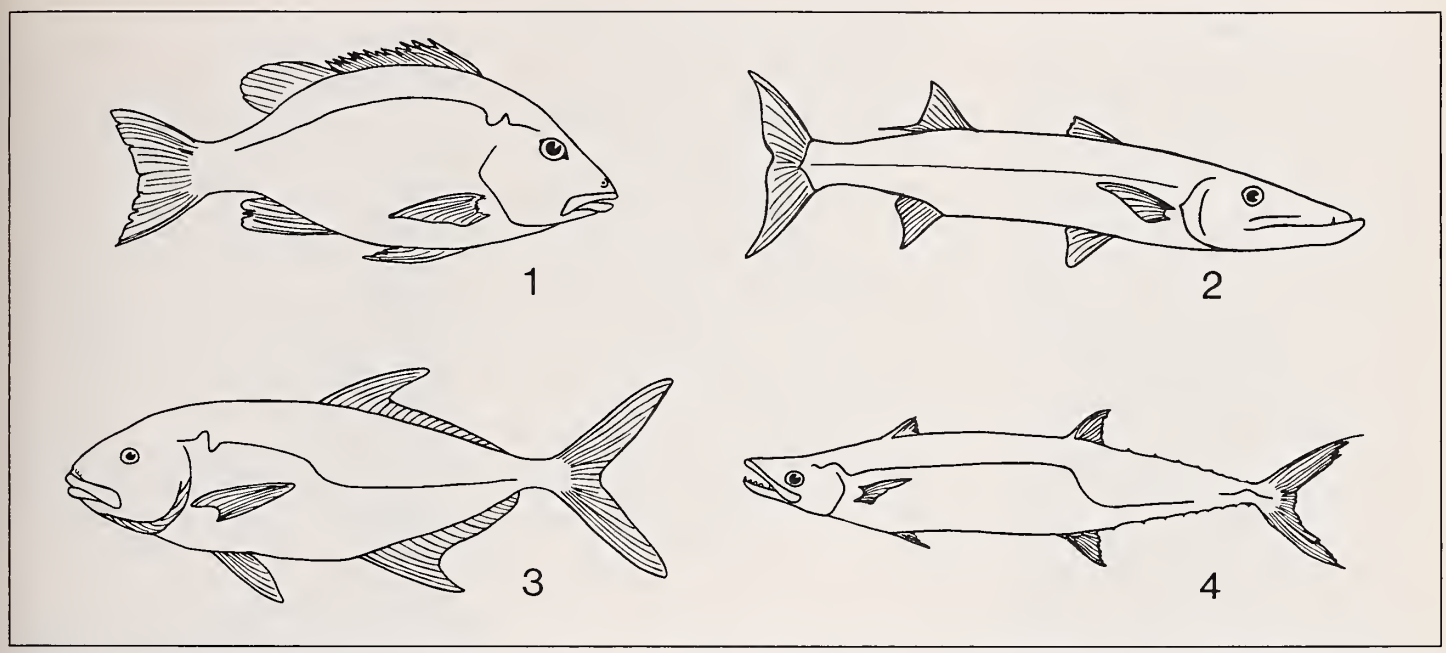

Figure 2. Reef fish frequently implicated in Ciguatera. 1. Snapper 2. Barracuda 3. Amberjack 4. King Mackerel

Dredging and blasting took place. The first ciguatera poisoning ever recorded in Hao occurred 3 years later and was attributed to an herbivorous fish. Two years later, carnivorous fish were implicated, and 43% of the population had been affected by ciguatera poisoning.[11]

In a similar study conducted in the Marshall Islands in 1982 by the World Health Organization Regional Office, 56% of families reported at least one family member poisoned within the last year. Previously, the Marshall Islands were the scene for 66 nuclear explosions between 1946-1958.[11]

The epidemiology of ciguatera poisoning is unclear. Ciguatera is not a reportable disease. Regional figures may not represent places of specific toxicity because the vector for disease is often a semipelagic fish which may migrate to and from a toxic region. A more serious problem is under-reporting. One estimate places the reported cases at 10-20% of the actual number of cases. The CDC places the actual reporting as low as 2-10%.[12]

There were no cases of ciguatera poisoning reported to the CDC from the lower Atlantic States (North Carolina, South Carolina, and Georgia) between 1974 and 1987. During this period 35 outbreaks were reported from Florida.[10] In the United States, Hawaii had the greatest number during this period (167), followed by Florida, Puerto Rico (14), and the Virgin Islands (10). The apparent lack of cases from Georgia and the Carolinas almost certainly reflects under-reporting or missed diagnosis. For example, the CDC was unaware of an outbreak in North Carolina during this period which affected six people.[13] Each outbreak of ciguatera poisoning affects an average of 4.5 people. With the recent increase in deep-sea fishing in the lower Atlantic States, the disease almost certainly is occurring in Georgia, since some of the implicated fish are preferred species for sport fishermen. Georgia physicians should be alert for ciguatera occurring in this state.

Pharmacology

Ciguatoxin

Ciguatera is caused by a number of toxins of which three have been isolated and identified. They are: ciguatoxin, scaritoxin, and maitotoxin. Ciguatoxin, the principal one, is colorless, odorless, and tasteless. It is thought to be an oxygenated polyether compound with a molecular weight of 1100.[5] It is a heat-stable and acid-stable molecule.[14]

The effects of ciguatoxin on neurotransmitter uptake and release by brain synaptosomes have been studied.[14] The toxin was extracted and purified from the Moray eel *(Gymnothorax javanicus)*. Toxicity was assessed by means of intraperitoneal injection in Swiss mice, which yielded a lethal dose 50 of 30 micrograms toxin per kilogram body weight.[14] Ciguatoxin clearly is an extremely potent toxin.

It has been shown that ciguatoxin drastically decreases the content of gamma amino butyric acid (GABA) and dopamine (DA) by brain synaptosomes.[14] GABA and DA are inhibitory neurotransmitters

which stimulate the influx of anions to hyperpolarize the cell and maintain a resting potential by counteracting the influx of cations. Therefore, when GABA and DA are reduced, the cell cannot protect itself from a falling membrane potential. Ciguatoxin appears to act by locking voltage-dependent sodium channels in the open position.[14] This allows for the unregulated influx of sodium ions adding to the depolarization which will eventually reach the threshold for an action potential. When the nerves are pretreated with tetrodotoxin, which comes from puffer fish and is known to block sodium channels, or when the nerves are placed in sodium-deficient medium, virtually all of ciguatoxin effects on nerve are inhibited.[14] Because ciguatoxin is specific for voltage-dependent sodium channels, it becomes the newest of six types of toxins specific to sodium channels.[14]

Others have elaborated on this idea by suggesting that the structure of ciguatoxin is related to its function. The ciguatoxin molecule is thought to have a region of moderate polarity and a region of low polarity similar to the phospholipid molecules which make up the lipid bilayer of the cell membrane. Its structure would then help it to blend into the bilayer and be in a stable location as it locks the voltage-dependent sodium channel in the open position, allowing the unabated entry of sodium ions and fluid.[15] The accumulation of fluid within peripheral nerves is often a result of ciguatera intoxication.

Maitotoxin

Maitotoxin, like ciguatoxin, is present in ciguatoxic fish.[1] Maitotoxin is water soluble and with a lethal dose of 0.17 micrograms toxin per kilogram body weight; this makes it the most potent marine toxin known.[16] In one study it was observed that even a small amount of maitotoxin (10^{-8}g/ml) triggered a large rush of calcium into pheochromocytoma cells and a correspondingly large efflux of [^{3}H] norepinephrine.[16] These observations were not significantly altered in the presence of tetrodotoxin (a sodium channel blocker), and the results were unchanged in a sodium-deficient medium. However, the effects were markedly inhibited by calcium channel blockers. This suggests that maitotoxin affects calcium channels. It is possible that maitotoxin is more common in herbivorous fish, whereas ciguatoxin is more common in carnivorous fish.[1]

Scaritoxin

Although very little research has been done on scaritoxin, it is believed to be lipoidal in nature and one of many toxins present in ciguatoxic organism. It may be responsible for the delayed development of ataxia, weakness, and tremor in ciguatera victims.[1]

Symptoms

Although as high as 93% of persons ingesting toxic fish become ill, the symptoms may vary greatly in type and severity even among individuals who ate from the same fish. As there are no specific diagnostic tests, the diagnosis is based on clinical presentation.[1] Because the ciguatoxin molecule is heat stable, cooking or other forms of treating the fish do not neutralize the toxin.

Symptoms usually appear between 4 and 48 hours following ingestion of toxic fish. There is no effective antidote. Bradycardia, hypotension, and occasionally tachycardia may occur.[1] Respiratory support may be necessary.[11] Death occurs uncommonly, usually from cardiorespiratory complications or severe dehydration.[1,15] In one series, there were only three deaths in 3,009 cases.[17] The most common symptoms are shown in Table 1.

Table 1—Common Symptoms Associated With Ciguatera

Symptoms	*%of Cases*
Diarrhea	70.6
Vomiting, nausea	37.5/42.9
Myalgia	81.5
Extremity dysesthesia	89.2
Perioral dysesthesia	89.1
Pruritus	44.9
Headache, vertigo	59.2/42.3
Weakness	60.0
Arthralgia	85.7

Adopted from Bagnis et al[17]

Other symptoms reported less than 50% of the time include perspiration, tremor, dental pain, neck stiffness, watery eyes, skin rash, dysuria, salivation, dyspnea, hypotension, and paresis.[17]

In one study, the mean time from ingestion of fish until onset of gastrointestinal upset was 5.7 hours. Gastrointestinal toxicity is usually of shorter duration than neurologic toxicity which may last for weeks, months, or even years. The neurologic problems appear an average of 20.5 hours after ingestion.[18] The severity of symptoms may be proportional to the amount of toxin ingested.

Paresthesias frequently are localized to the palms and soles. An interesting symptom of ciguatera poisoning, as yet unexplained, is hot-cold temperature reversal (where cold objects produce hot, burning sensations). Heated objects in contact with the skin do not produce unpleasant sensations. Burning sensations in the mouth, oropharynx, and nasal mucosa may occur as direct peripheral nerve effects of the toxin passing through mucosal membranes, occurring during ingestion. Less commonly observed neurologic symptoms in-

clude metallic taste, photophobia, ataxia of gait, and fatigue.

Despite the intense and rich symptomatology, a recent electrophysiologic study of nerve and muscle detected only minor abnormalities.[13] Repeated attacks of ciguatera intoxication in the same individual tend to be more severe, and symptoms may be exacerbated by alcohol, exercise, or other foods.[15] Ciguatera poisoning in pregnant women may result in abortion or premature labor; at birth, infants may be affected. The disease may be transmitted by breast feeding.

Treatment

Ciguatera is difficult to diagnose; in truth, it is often misdiagnosed. Treatment is supportive and symptomatic, and although there is no cure, certain drugs have been tried with varying degrees of success. A few of these are nifedipine, amitriptyline (to control pruritus and dysesthesias)[6] and tocainide.[19]

One new and promising treatment involves the use of intravenous mannitol.[20] Mannitol, a six-carbon sugar-alcohol derived from plants, is most often used clinically as an osmotic agent to treat cerebral edema and as a means to increase blood volume as a prophylaxis to prevent acute renal failure. Its benefits in ciguatera were discovered unexpectedly while two patients were being treated for cerebral edema.[20] During evacuation to a medical facility, both patients were comatose and reportedly suffering from severe ciguatera poisoning. The physician feared cerebral edema, and mannitol (1 g/kg at a rate of 500 ml/hr) was given intravenously. Within 10 minutes both patients were awake, sitting up, and asking questions. After 48 hours, both were discharged from the hospital fully recovered. In 17 of 23 additional patients, all neurologic manifestations completely resolved within 48 hours of beginning mannitol.[20] Good results have also been obtained in a series of twelve patients using intravenous mannitol as a treatment for severe ciguatera poisoning.[21] And while additional efficacy and safety studies must be performed, mannitol appears to be a safe and effective treatment for some, if administered in the initial acute phase.[18, 21]

The principal toxin is ciguatoxin, which acts on mammalian nerve cells by locking voltage-dependent sodium channels open. The resulting uncontrolled influx of sodium ions causes dramatic changes in the membrane potential.

The mechanism for mannitol's dramatic effects in ciguatera are unknown, but it has been suggested that it acts as a scavenger for hydroxyl radicals. The ciguatoxin molecule is thought to posses such hydroxyl groups.[15] Mannitol also acts as an osmotic agent by drawing fluid from tissues. Since one effect of ciguatera poisoning is the accumulation of excess fluid within Schwann cell and axonal cytoplasm, mannitol should be beneficial.

The only preventive measures to avoid ciguatera, short of not eating salt water fish altogether, is to eat only strictly pelagic species (e.g., tuna), to avoid all barracuda, and less safe, to avoid large specimens of species frequently tainted (e.g., snapper, amberjack, mackerel, grouper, etc.).

Conclusion

G. toxicus is responsible for ciguatera poisoning. The vector for infection are fish which accumulate the toxin as it is passed up the food chain. Symptoms of ciguatera poisoning are the results of at least three known toxins, ciguatoxin, maitotoxin, and scaritoxin. The principal toxin is ciguatoxin, which acts on mammalian nerve cells by locking voltage-dependent sodium channels open. The resulting uncontrolled influx of sodium ions causes dramatic changes in the membrane potential.

Maitotoxin, the most potent marine toxin known, is present in a much smaller quantity than ciguatoxin and is specific for voltage-dependent calcium channels.

Although not reported from Georgia, the disease probably occurs here. The clinical symptoms of ciguatera intoxication occur in two stages: first gastrointestinal, then neurologic. Of the two types, the neurologic complications are the most severe. Unpleasant paresthesias are the most characteristic symptom, but many others occur. They are usually self limiting but in certain cases may persist for months or even years. Sensitization to alcohol, exercise, stress, ciguatoxic foods, and even non-ciguatoxic seafoods may result in a reoccurrence of symptoms.

Although no cure has been found, mannitol is the most promising treatment available. Given intravenously, it works in an osmotic manner to shrink swollen tissues. It probably helps to alleviate the water build up in nerves of ciguatera patients and may act as a scavenger for hydroxyl radicals on the ciguatoxin molecule. The development and implementation of a method to detect tainted fish before marketing will be a major step forward in controlling this disease. Georgia residents (consumers and physicians) should be alert for the occurrence of ciguatera in this state.

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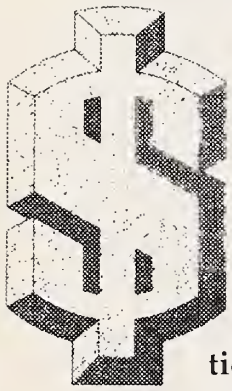

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Peer Review of Expert Testimony

Randy Hanzlick, M.D.

Peer review of medical expert testimony is something that our profession should consider to protect its integrity and the rights and liberties of those drawn into the court system.

Introduction

PEER REVIEW processes are common and required in many hospital and medical practice settings, yet such review is virtually absent when medical expert testimony is rendered in the civil or criminal legal arena. Since the rendering of medical testimony closely parallels the practice of medicine, it seems appropriate that a formal mechanism exist which enables random and specific review of testimony. When one considers that people's rights, freedom, financial security, and professional status may be adversely affected by medical expert testimony, it seems just as important to ensure the quality of medical testimony as it does to ensure the quality of diagnosis, treatment, patient management, and medical practice in general. This paper discusses the need for peer review of testimony and offers suggestions to initiate not only discussion but also some corrective action as well.

Why Peer Review is Needed

It must be recognized that during depositions of medical experts and in courtrooms where medical evidence is presented, there are seldom other medical experts present at the time of the testimony. Misrepresentations, overstatements, half-truths, understatements, incompetence, outright lies, and other errors may go totally undetected, all the while influencing the trier of fact (judge or jurors) and the case substantially. Although the potential for peer review theoretically exists within the adversary legal system in the form of cross examination, offering of rebuttal witnesses, or prosecution for perjury, these mechanisms are not uniformly or adequately used from the medical quality control standpoint. It does not seem medically appropriate for the quality of medical testimony to be evaluated solely or primarily by attorneys, judges, and lay jurors. These individuals are usually required to make decisions based on legal criteria, not medical knowledge and facts.

For several reasons, we as physicians cannot rely routinely on attorneys and the legal system to monitor medical testimony. First, many attorneys do not have the time, resources, interest, or insight to obtain second opinions on medical testimony. Second, attorneys are

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usually not physicians and often lack the expertise to recognize improper testimony. Third, unless attorneys know that their witness is lying or incorrect, they are bound by their code of ethics to present evidence which they believe is true, exculpatory, or in their client's best interests. Such evidence may or may not be medically accurate. Fourth, the legal profession should not have the responsibility of policing the medical profession which should have the foresight, required knowledge, and integrity to police itself. Fifth, the integrity of the medical profession is not a primary concern of the legal profession. For these reasons, we as medical professionals should commit to monitor our testimony and take investigative or corrective action when needed.

A surgeon who removes the wrong tissue or continually uses unorthodox or overly aggressive treatments will probably be detected and disciplined via established peer review mechanisms. There is a much smaller chance, however, that an unorthodox or overly aggressive medical expert witness will be recognized by judges, attorneys, and laypersons in a predominantly legal setting to the point that corrective action is taken. Unlike the surgeon who frequents the same operating room and is observed repeatedly by the same individuals, the expert witness may carry out his or her duties in a different courtroom with new players each time he or she "performs."

One major problem is that attorneys are in the habit of paying for medical expert testimony. Since a professional service is being rendered, such payment seems appropriate in many cases. However, the potential for financial and other personal gain to the witness adds an impetus for testimony which may be independent of the altruistic search for truth and justice. Fees for medical services are somewhat standard and regulated, yet expert witness fees are uncontrolled and limited mainly by what attorneys are willing to pay or by the concern of being asked on cross examination how much is being paid for the opinion. The latter concern seldom provides the impetus to turn down the money, and some medical expert witnesses are now charging up to a $3000 retainer simply to become involved in a case. Such practices can put a black mark on our profession, since money can be perceived as the impetus rather than concern about the quality of medical practice. We must acknowledge the potential for and existence of "hired testimonial guns" who abuse the system to their own advantage. Since an individual's liberties and well being are often at stake, our professional responsibility should include taking steps to minimize medical abuse of the already plagued legal system.

Informative and enlightening data could be gathered concerning the frequency of medical expert testimony, the identity of those who testify often, disclosure of habitual attorney-physician associations, disclosure of certain attorneys who habitually seek out the same judges, and income derived through testimony.

When an impropriety of medical testimony occurs in a legal case, the typical legal approach involves an attempt to discredit or embarrass the witness under oath. That approach may or may not work in court and may or may not result in a proper legal judgement; regardless, it does little good to involve the medical profession in corrective action to prevent future occurrences. In short, there is no formal feedback mechanism between the legal and medical professions. Peer and professional review of testimony is one way to address this problem.

Another problem is the physician who simply testifies beyond the scope of his or her competence. In some cases, this is as gross as a non-physician rendering medical opinion. Another example is the pathologist who testifies that the surgical care of a patient was substandard and negligent. Although he or she may have been correct in that opinion, it would seem medically appropriate and more sound from a legal standpoint if that statement had come from a surgeon in a similar specialty area, unless, of course, the concept of "res ipsa loquitur" applies and the negligent act speaks for itself. There is no mechanism at this time to prevent improper testimony other than an interested party making an issue of such an episode. Testimony outside one's area of expertise is commonplace in the area of forensic sciences. Improper testimony may occur without an intent to deceive and without a violation of ethics. A system should be in place designed to review such problems medically, objectively, and officially without placing anyone at risk for undue criticism or sanctioning. To date, no such mechanism exists.

The "hired gun" witness, the existence of which is acknowledged by both the medical and legal professions, continues to be actively sought and used by the legal profession while the medical profession allows this phenomenon to continue. Such characters constitute routine conversation at medico-legal and forensic society meetings. Yet they are nationally

known in legal circles, well paid, and used frequently. Their propensity for overstatement and half-truths is well known, yet it occurs repeatedly without disciplinary action by the medical or legal profession. It would be much easier to identify and discipline such perpetrators if their footsteps could be traced. There is no readily accessible way to find out when and where a given physician has testified (let alone what the witness testified to) unless one has personal knowledge of a particular legal case to research. Witness data banks do exist, but they are not comprehensive nor do they include deposition testimony, and they are designed for use primarily by attorneys. Formalized tracking of testimony by the medical profession would make investigation of alleged "hired gun" medical experts much easier to accomplish.

Establishing a Medical Expert Testimony Data Bank

Since the medical expert usually gains his or her status as an expert by virtue of the State-granted privilege of medical licensure, and since the courts gain their authority through the State, the State should be entitled to collect information on medical expert testimony. The Medical Association should be interested in the collection of such information as well, since the practice of medicine is involved. Regardless, a mechanism for collecting information would be relatively simple to develop. The Composite State Board of Medical Examiners (the "Board") could require that each time a physician offers expert medical testimony in the form of an affidavit, deposition, or testimony under oath, a "witness form" be submitted by the clerk or court reporter. The form would include the following information which would be maintained in an accessible data base:

1) The date that the expert opinion or testimony was rendered
2) The type of evidence (affidavit, deposition, testimony)
3) The type of case (civil vs. criminal)
4) The nature of the case (homicide, product liability, etc.)
5) The party for whom evidence was rendered (plaintiff/defense)
6) The name and address of the witness
7) The name and address of the law firm using the witness
8) The court, county, docket number, and judge's name
9) The amount of the professional witness fee, if known.

The private medical expert consultation business is booming, and we need to take steps to ensure that the business end of the deal does not overshadow the professional ethics to which we are bound as physicians.

Formal complaints about specific testimony could be voiced to the Board, which, if necessary could use an ad hoc panel of medical jurisprudence experts and experts in the appropriate medical specialty to evaluate the specific testimony in question. If improper testimony seemed to occur, the database could be searched by witness name to acquire additional testimony for review. The statute could empower the Board to sanction physicians for improper testimony, particularly if it is an habitual occurrence. The data could also be made available to parties with a legitimate interest, such as peer review factions of the various medical organizations. Random reviews and study would also be facilitated by the database. Much like hospital tissue review committees use the frequency of non-diseased tissue removal as a marker for possible improper practice, the frequency of testimony may also serve as a marker for physicians whose testimonial practices warrant scrutiny.

Both the medical and legal professions could learn much about their inter-relationships, shortcomings, and contributions by adopting such a system. The data base would allow for identification of the types and location of cases tried. This would afford a convenient aid in tracking down and obtaining case transcripts. Informative and enlightening data could be gathered concerning the frequency of medical expert testimony, the identity of individuals who testify often, disclosure of habitual attorney-physician associations, disclosure of certain attorneys who habitually seek out the same judges, and income derived through testimony. Further, we would be able to study bias and inconsistencies in testimony and evaluate the quality of testimony to educate ourselves on how to be more objective, better witnesses. We could also study what aspects of medical expert testimony are crucial to the outcome of cases, and get a better handle on when and where we have erred and how we can improve. These are just some of the benefits of adopting a system which fosters peer review of testimony.

I recently ran across a cartoon in which a young man was introducing himself to a lady at a party. She asked the man what he did for a living. His reply was something to the effect that he "made his living by frequenting that shady zone that lies somewhere between medicine and law." That is not an image that I am particularly proud of, particularly as a forensic pathologist. The private medical expert consultation business is booming, and we need to take steps to ensure that the business end of the deal does not overshadow the professional ethics to which we are bound as physicians.

The legal system seems to be stretching those ethics to extremes, and the only logical way to protect the integrity of our profession is to monitor how we interact with the legal system and take corrective action if required. Peer review of testimony may be of help.

The concept of peer review of medical expert testimony has been previously addressed in the forensic science literature.[1,2] The State of Florida has passed legislation which enables the Department of Professional Regulation to discipline physicians who give false, substandard, or unprofessional expert testimony either by affidavit, deposition, or courtroom testimony. Sanctions could not be imposed simply for testifying too often, but there is no reason why the regulatory board would be prevented from censuring a physician whose testimony was habitually improper from the medical standpoint. The Florida statute is a step in the right direction, but the law does not facilitate random review, the details and risks of initiating an inquiry are not specified, and the practical benefits of this law remain to be seen. Perhaps Georgia could establish a statute which not only enables disciplinary action if warranted, but promotes education as well through peer review.

It does not seem medically appropriate for the quality of medical testimony to be evaluated solely or primarily by attorneys, judges, or lay jurors.

Peer review of medical expert testimony is something that our profession should consider to protect its integrity and the rights and liberties of those drawn into the court system. If further discussion of the peer review concept occurs, the goal of this paper will have been fulfilled.

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Health Care Professionals Indicted on Antitrust Charges

Robert N. Berg

A LITTLE OVER a year ago, this Legal Page[1] was devoted to providing physicians with an overview of the "criminal" side of the U.S. antitrust laws. At that time, the Department of Justice had indicated that it was ending its efforts to educate health care professionals on the application of the antitrust laws; instead, that Department expressed its intent to commence criminal proceedings against health care professionals engaging in "hard core" antitrust violations. In particular, the Department suggested that it would prosecute health care professionals engaging in agreements to fix prices, allocate territories, or boycott competing health care providers.

Dentists Indicted for Price-Fixing Conspiracy

On February 7, 1990, the Department of Justice made good on its promise, announcing that a Federal grand jury in Tucson, Arizona, had returned a one-count felony indictment charging three dentists and two professional dental corporations with conspiring to fix co-payment fees paid by patients who were members of several prepaid dental plans in Tucson, Arizona.[2] The indictment charged that, from May, 1987, through the date of the indictment, the defendants conspired, among themselves and with others, in violation with Section 1 of the Sherman Act,[3] to fix and raise the co-payment fees paid by members of four prepaid dental plans. The indictment listed several actions which allegedly were taken by the defendants in furtherance of this conspiracy, including:

1. Attending meetings at various dental offices, to discuss the level of co-payment fees in the Tucson, Arizona, area.
2. Agreeing on higher co-payment fees to be paid to the defendants and co-conspirators, by the members of at least four prepaid dental plans.
3. Agreeing to submit identical letters demanding that the four dental plans adopt the agreed-upon co-payment fees.
4. Mailing identical demand letters and higher co-payment fees schedules to the four dental plans.
5. Pressuring at least three of the dental plans to raise co-payment fees in the Tucson, Arizona, area.
6. Causing the members of at least three of the dental plans to pay higher co-payment fees to the defendants and co-conspirators.

"In announcing the indictment—the first felony antitrust indictment returned against medical practitioners in over 50 years—the Department of Justice made it clear that other indictments would follow in the future."

In announcing the indictment—the first felony antitrust indictment returned against medical practitioners in over 50 years—the Department of Justice made it clear that other indictments would follow in the future. "Price fixing among competitors is a crime," said James F. Rill, Assistant Attorney General in charge of the Antitrust Division. "Doctors enjoy no immunity from this well-settled rule; when professionals fix prices, they will be pursued and prosecuted for the crime."[4]

This has been a consistent theme espoused by the Department of Justice over the last year. For example, in November, 1989, a senior official

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in the Department sounded a similar warning:

If two or more doctors in the same specialty, but with independent practices, agree to raise their fees to patients or third-party payors, they are engaging in price-fixing. The same would be true if those doctors agreed not to reduce their fees or to give a discount to patients or a particular third-party payor, or if they agreed simply to limit the discount they would give. Their agreement doesn't have to be formal or in writing. You should be wary, therefore, when you hear about a meeting of competing providers where they are only just discussing or exchanging current or future fee data. These exchanges can easily turn into a price-fixing agreement. We will proceed against this activity criminally.[5]

Prosecution of alleged antitrust violators by the Department of Justice involves potentially significant adverse consequences to physicians and other health care practitioners. For example, if convicted, the individual dentists in the *Alston* case face up to 3 years in prison and the greatest of three alternative monetary penalties: (i) a $250,000 fine, (ii) twice the pecuniary gain the individual derived from the crime, or (iii) twice the pecuniary loss caused to victims of the crime. For the two professional corporation defendants, the maximum monetary penalty would be $1,000,000 or the latter two of the three alternatives listed above for individuals.

Increased Cooperation Among Antitrust Regulators

While the Tucson indictment is noteworthy in its own regard, it is also important for another reason: It represents an instance where the Department of Justice initiated a criminal prosecution, following referral of the case from the Federal Trade Commission (FTC), the other Federal agency charged with responsibility for enforcing the antitrust laws. This referral from the FTC to the Department of Justice raises troubling, serious issues, and may cause health care practitioners to reconsider the manner in which they deal with the FTC in the future.

‘Cooperating with the FTC in the future may take on a whole new dimension, however, if the FTC takes the information obtained from the cooperating health care practitioners and refers the matter to the Department of Justice for criminal prosecution.’

Specifically, health care practitioners in many cases have leaned toward cooperating with the FTC, when that agency conducts an investigation. This is so for a number of reasons, but primarily because the FTC's enforcement authority, at least in the first instance, does not go beyond preventing the unlawful activity from continuing. Accordingly, health care practitioners have been more willing to cooperate with the FTC, where the worst case outcome in all likelihood would involve nothing more than the entering into of a Consent Order, prohibiting the unlawful conduct from continuing.

Cooperating with the FTC in the future may take on a whole new dimension, however, if the FTC takes the information obtained from the cooperating health care practitioners and refers the matter to the Department of Justice for criminal prosecution. In that case, it is far more likely that the health care practitioners would choose not to cooperate with the FTC in the first instance, instead providing information, documents, and records to the FTC only as mandated by law. This in turn may make it far more difficult for the FTC to obtain informal corrective action, or enter into Consent Orders without going through the full-blown litigation process.

In addition to cooperating with the Department of Justice, the FTC has also indicated its intention to cooperate more closely with the various State Attorneys General, not only in providing those local enforcement agencies with information and leads, but also in providing manpower and resources which may be used by those local agencies in prosecuting potentially violative antitrust conduct under local laws. Thus, in one case, the FTC has been working closely with the Attorney General of the State of Colorado, by giving subpoenaed documents to the State staff (which itself does not have subpoena power in antitrust cases), and also by making available one of the FTC staff economists, to provide analysis and testimony.[6]

Conclusion

In summary, the Department of

Justice clearly intends to continue its active pursuit of unlawful antitrust activity by health care professionals and to bring indictments when warranted. There are at least two current grand jury investigations in process (in Boston, Massachusetts, and Savannah, Georgia), and it is likely that other grand jury investigations will be opened in the near future. In addition, it is likely that State agencies will become more actively involved in prosecuting conduct alleged to violate local antitrust statutes.

Notes

1. Berg, "Application of Criminal Antitrust Sanctions to Health Care Professionals," *Journal of the Medical Association of Georgia*, Vol. 78, No. 2, pp. 102-104 (February 1989).
2. *United States v. Alston et al.*, U.S. District Court, District of Arizona, Crim. No. CR 90-042-TVC (February 7, 1990).
3. 15 U.S.C. §1.
4. Press Release issued by the Department of Justice on Wednesday, February 7, 1990.
5. Remarks of Robert E. Bloch, Chief, Professions and Intellectual Property Section, Department of Justice, presented on November 4, 1989, to the Thirty-Third Annual New England Antitrust Conference, Cambridge, Massachusetts. (Footnotes omitted.)
6. Remarks of Janet D. Steiger, Chairman, Federal Trade Commission, presented on February 15, 1990 before the National Health Lawyers Association, Washington, D.C.

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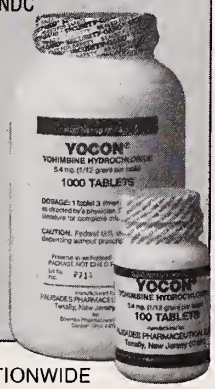

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Diagnosis of Renovascular Hypertension: The Captopril Stimulation Test

W. Dallas Hall, M.D.

Introduction

RENOVASCULAR hypertension is often suspected by the abrupt onset or worsening of hypertension in a patient below age 35 (fibrous dysplasia type) or above age 60 (atherosclerotic type).[1] Other clinical clues include resistant hypertension, an epigastric bruit that radiates laterally, hypokalemia (due to secondary aldosteronism), and a lean body habitus. In addition, the prevalence of renovascular hypertension is doubled in patients with diabetes mellitus,[2] but reduced approximately six-fold in hypertensive blacks. Davis et al[3] performed renal arteriography in 85 patients who presented with a diastolic blood pressure above 124 mm Hg plus grade III or IV retinopathy. Renal artery stenosis (≥ 25% narrowing) was found in two of 29 blacks (7%) and 24 of 56 whites.

For years, the rapid sequence intravenous pyelogram (RSIVP) was the preferred initial diagnostic test.[4,5] However, even with technically adequate films, the sensitivity of this test was only 75-80%, implying that 20-25% of patients with significant renovascular hypertension would have a normal RSIVP. The false negative test rate led to the popular use of intravenous digital subtraction angiography (IVDSA) as an initial screening test,[5] with gradual demise of the RSIVP.[6] It soon became apparent, however, that the sensitivity of the IVDSA was probably no better than 85% (especially for segmental lesions), and that false positive tests also occurred (e.g., pseudo-narrowings where the superior mesenteric artery crosses over the right renal artery near its origin). Arterial digital subtraction angiography, using a smaller caliber needle and less contrast, has now largely replaced IVDSA in most but not all centers.[7,8]

Captopril Stimulation Test

In 1979, Case et al[9] described the principles of the captopril stimulation test. Subsequently, McGrath et al[10] reported that seven of eight patients with renal hypertension (but none of 10 patients with essential hypertension) exhibited a rise of plasma renin concentration of 2.5 ng/ml/hr or more 1 hour following a single 25 mg oral dose of captopril.

Mechanisms for the rise in renin following angiotensin converting enzyme inhibition include stimulation of renin release by the fall in blood pressure; interruption of the negative feedback by which angiotension II suppresses renin release; and decrease in renal blood flow and glomerular filtration rate[11] with reduced distal delivery of sodium on the stenotic side.

"Patients with abnormal renal function often exhibited a false negative captopril test in the presence of renal artery stenosis, and a false positive test in the absence of renal artery stenosis."

The captopril stimulation test was popularized considerably by the 1986 publication by Muller et al[12] who reported 100% sensitivity and 95% specificity in 42 patients with renovascular hypertension (≥ 75% narrowing of the renal artery) and 200 patients with essential hypertension. Diuretics were withheld for at least 4 days (spironolactone for 4 weeks), and all patients had a 24-hour urinary sodium excretion of 50 mEq or more. The criteria for a positive test included a 1-h post-captopril (50 mg) sitting plasma renin

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activity (PRA) of 12 ng/ml/h* or more, an absolute PRA increase of 10 ng/ml/h or more, *and* a 150% increase in PRA (or 400% if the baseline PRA was below 3 ng/ml/h). These results, determined retrospectively,were in patients with renovascular or essential hypertension who did not have abnormal renal function, defined as a serum creatinine of 2 mg/dl or more, or between 1.5 and 2.0 if the blood urea nitrogen was 25 mg/dl or more.

In patients with abnormal renal function, only 11 of 14 patients with renovascular hypertension had a positive captopril stimulation test (79% sensitivity), whereas 10 of 33 patients without renovascular hypertension had a positive test (70% specificity). False positive tests occurred in 43% of patients with renal dysfunction associated with nephrosclerosis, malignant hypertension, primary aldosteronism, scleroderma, or intrinsic renal disease. Thus, patients with abnormal renal function often exhibited a false negative captopril test in the presence of renal artery stenosis, and a false positive test in the absence of renal artery stenosis. Although the patients with renovascular hypertension had higher average baseline levels of PRA and a greater reduction in mean arterial pressure 1 hour following captopril therapy (i.e., 18.7 mm Hg versus 7.3 mm Hg), there was considerable overlap between the groups, and neither of these features was useful to discriminate well between renovascular and essential hypertension.

* 12 ng/ml/h using the Laragh technique is equivalent to 9.2 ng/ml/h (Biotech), 7.3 ng/ml/h (Metpath, Roche, Nichols) or 5.7 ng/ml/h (Smith-Kline, Mayo)

Gosse and coworkers[13] applied the Muller criteria prospectively in 103 referred hypertensive patients, all of whom underwent either IVDSA or arteriography. The captopril test was positive in eight of 11 patients with renal artery stenosis (≥ 70% narrowing), but also in 15 of 92 patients without renal artery stenosis. Of the three patients with a false negative test, one had abnormal renal function. Thus, used prospectively, the captopril test had a sensitivity of 73% and a specificity of 84%.

"The absolute and percentage change in PRA did not improve the sensitivity of the captopril test, and the authors recommended a single post-captopril PRA level as a simplified and economical screening test for renal artery stenosis."

Postma et al[14] evaluated the captopril test in 149 consecutive hypertensive patients who had IVDSA or arteriography performed. An unacceptably low sensitivity (38%) was found, even in patients with creatinine clearances above 70 ml/min. They concluded that the captopril test was unfit for use as a screening procedure in unselected hypertensive populations. Two variations in the methodology of this study were the use of captopril in a dose of 25 rather than 50 mg, and conduct of the study in the supine rather than the seated position.

Fredrickson et al[15] reported captopril test results in 100 patients, 29 with renal artery stenosis (≥ 75% narrowing) and 71 with presumed essential hypertension (only 15 of whom had arteriography). Medications were either withheld or, as necessary, changed to shorter-acting drugs (e.g., labetalol or nifedipine) continued through the evening prior to the test. Patients who had taken an angiotensin converting enzyme inhibitor within 10 days were excluded from the study. All 29 patients with renal artery stenosis had a positive captopril test (i.e., 100% sensitivity) defined as a PRA of 5.7 ng/ml/h 1-h post captopril (equivalent to 12 ng/ml/h using the Laragh technique). However, 14 of the 71 patients with essential hypertension also had a positive test, providing a specificity of 80%. Diuretic therapy was continued until the evening before the test in 38 patients and may have contributed to the relatively high number of false positive tests. The absolute and percentage change in PRA did not improve the sensitivity of the captopril test, and the authors recommended a single post-captopril PRA level as a simplified and economical screening test for renal artery stenosis.

Gaul and associates[16] reviewed 16 papers that reported pre- and post-dose PRA levels in 805 patients following single dose captopril. Ten of the 16 studies showed a significantly greater post-captopril increase in PRA in patients with renal artery stenosis as compared to patients with essential hypertension. They concluded that the captopril test may be useful for the diagnosis of renovascular hypertension.

In summary, the captopril stimulation test is useful in the screening of hypertensive patients for the presence of renal artery stenosis. It is clearly preferable to random measurement of PRA. Inappropriate elevations of the sitting PRA (i.e., above 5.7-12 ng/ml/h, depending on the method used) 1-h after a 50 mg test dose of captopril are detected in the vast majority of patients with renal artery stenosis, but the major problem is false positive tests in patients with essential hypertension. A positive captopril test should be interpreted "tongue-in-cheek" in any patient with a serum creatinine level of 2 mg/dl or more, or between 1.5 and 2 if the blood urea nitrogen is 25 mg/dl or higher. Also, the test can be false negative in patients who have a suppressed PRA level while receiving beta blockers, or false positive in patients who have recently received diuretic therapy or adhered rigorously to a low sodium diet. Blood pressure should be monitored every 15 minutes for 2 hours after the 50 mg oral dose of captopril, since occasional patients develop hypotension and require being placed in the supine position with infusion of intravenous saline.

The captopril stimulation test must be considered in context of other recent noninvasive screening tests for renovascular hypertension. For example, renal scintigraphy (^{99m}DTPA and ^{131}iodohippurate) before and 1 hour following 25-50 mg captopril often shows a captopril-induced functional impairment of uptake by the kidney ipsilateral to the stenosis.[8, 17, 18] The double renal scans, however, are time consuming and expensive. Percutaneous renal duplex ultrasonography provides b-scan images and fast-Fourier transform spectral analysis of the Doppler frequency shift in the aorta and renal arteries. Significant renal artery stenosis (≥ 60% narrowing) is predicted by a renal to aortic peak systolic velocity ratio of 3.5 or more, but the duplex examination can be technically inadequate in the presence of obesity or excessive bowel gas.

‘Blood pressure should be monitored every 15 minutes for 2 hours after the 50 mg oral dose of captopril, since occasional patients develop hypotension and require being placed in the supine position with infusion of intravenous saline.’

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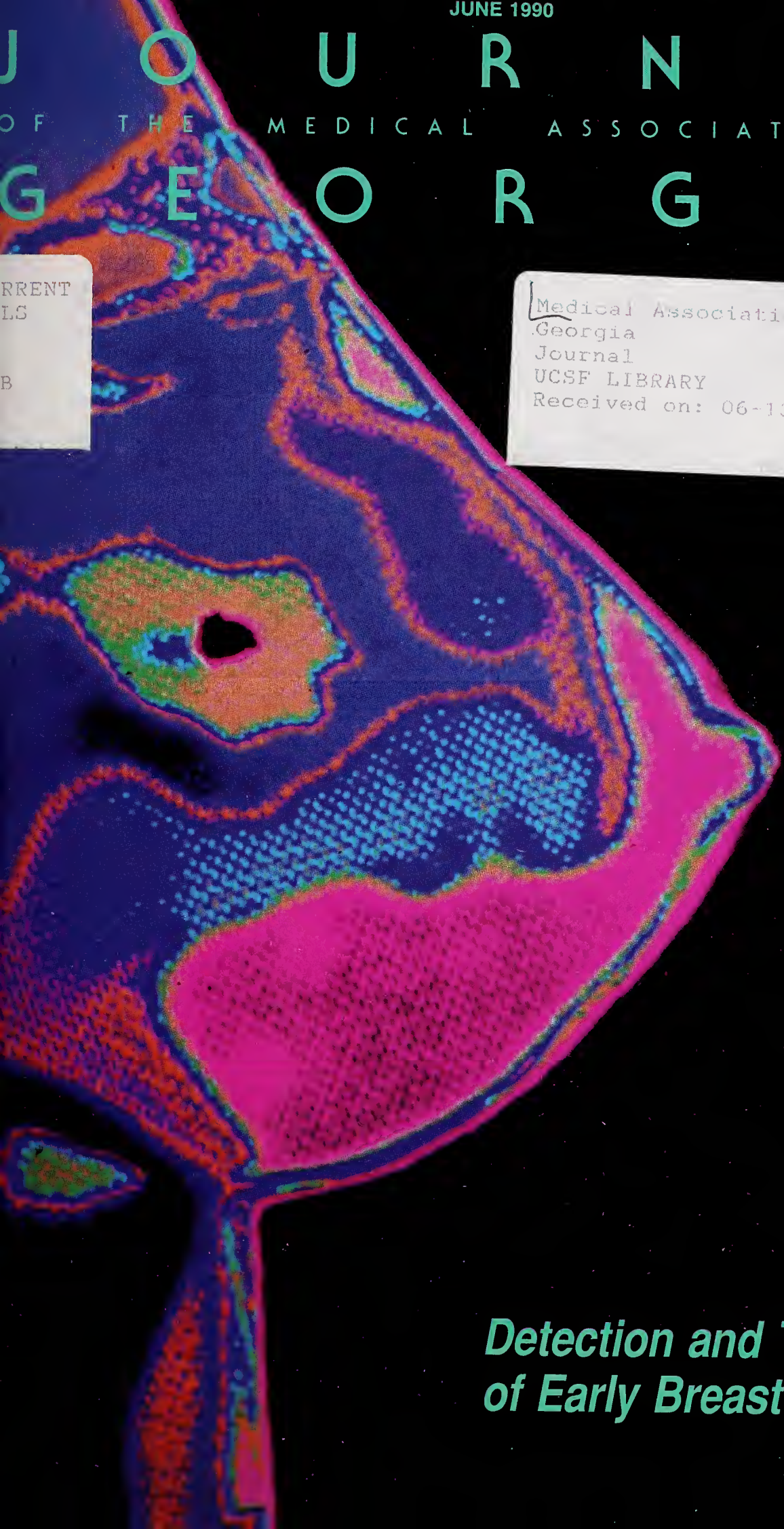

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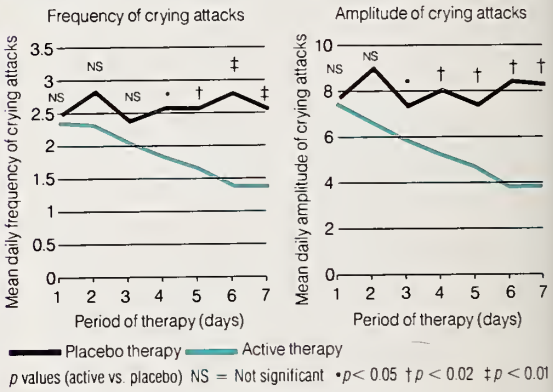

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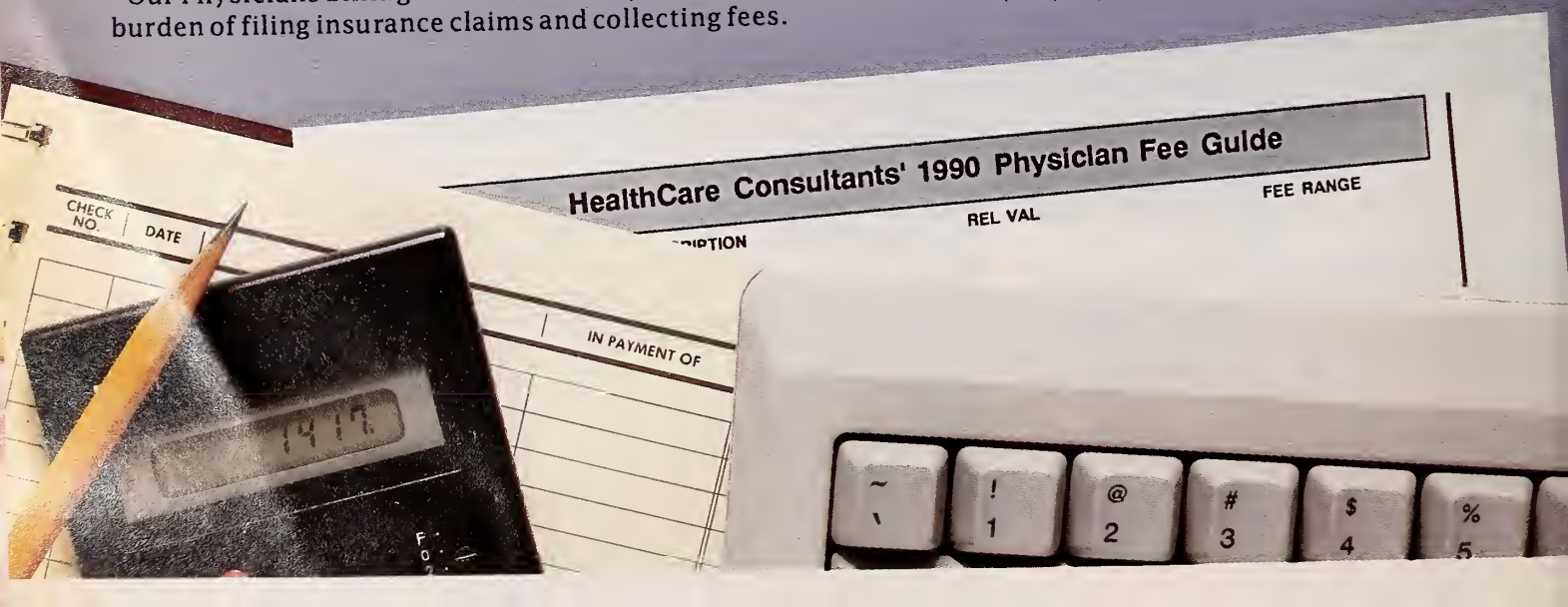

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THE COVER

Computer color enhancement of plain film mammogram of female breast using Megavision 1024 XM computer graphic workstation. By Howard Sochurek, New York City.

This issue of the *Journal* features five articles that discuss various aspects about breast cancer, including the Cancer Page by a Canadian surgeon.

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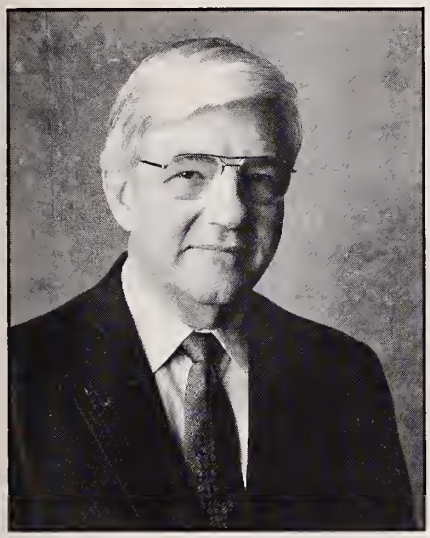

Strange Bedfellows

'TIS SAID that at Christiana's Tavern, in the early Virginia Capital of Williamsburg, a shortage of rooms to let led to the famous statement, "Politics makes strange bedfellows." Rooms and, in turn, beds were in short supply during the meeting of the legislature when all of the politicians and the followers of politicians would arrive in the capital. One could only rent a portion of a bed for 4 hours before he would have to get up and allow someone else to sleep for 4 hours. Consequently, one would never know whom one would wake up in bed with after 4 hours of repose. Hence, the famous statement.

'Don't just stand there in the Lake of Indifference and complain because no one threw water on your burning barn.'

Lest anyone forget, it is that time of the year and that year of the election cycle that is causing such a stir across the state. We have probably more competent candidates running for Governor than we have perhaps ever had in the history of our State, and it is certainly the Medical Association of Georgia's desire that each physician will pick a candidate of his choice and work for him, supporting him to his legal limits, if possible. It is said by many politicians that physicians do not get "involved" in politics and, hence, that is why they give so much ear to the limited practitioners who not only will send money but also will get out and put up yard signs and speak at Rotary Clubs and pass out cards in their offices — all of the things that politicians consider to be so valuable in their campaigns.

In years and centuries past, physicians were among the more educated members of the community and took a more active role in the political goings on. Often as many as 10 and 20% of early legislative bodies were made up of those listing themselves as physicians by profession. Although modern times and practices do not lend themselves well to physicians practicing medicine and being part of the body of politics, we certainly can support our candidates with our actions, time, and our money.

Many physicians seem to consider themselves above politics, as if it were something dirty that would soil their hands. The physician who says he is not interested in politics is like the drowning man who insists he is not interested in water. Physicians must realize that their ability to practice, the scope of their practice, and the manner in which they may practice may never be any safer than the actions taken by the last meeting of the Legislature or the Congress. Limited care practitioners readily understand that their license to practice is granted by the State Legislature; however, some physicians seem to think that they were ordained by God.

Approximately 28 years ago, GaMPAC was formed in an effort to create monies for support of candidates who would favor quality medical care in the state and nation and, to this point, it has been reasonably successful. Yet only 20% of the physicians in this state contribute to GaMPAC, making the average gift given by a physician for political action in this state a paltry sum compared to what it could be if all physicians felt their duty to contribute to the political process. Admiral Nelson, at the Battle of Trafalgar, flashed to his troops the famous statement, "England expects every man will do his duty." I would paraphrase Nelson to the extent that the Medical Association of Georgia expects every doctor to do his duty and that duty will include supporting the candidate of his choice in the election to come and those choices will be influenced, to a great degree, by how well that candidate has supported delivery of quality health care to the patients of the State of Georgia in the past. Write GaMPAC or the candidate of your choice a check, put up a yard sign, or pass out a card.

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Young, Thomas W., Forensic Pathology — MAA — (Active) Fulton County Medical Examiners Office, 50 Coco Cola Place, Atlanta 30303

PERSONALS

Clayton-Fayette CMS

Ernest Dunbar, Jr., M.D., Clayton County's first pediatrician, was honored recently at a "roast" conducted by the anti-drug abuse organizations, Youth to Youth and Just Say No Clubs.

Dr. Dunbar was recognized for his many years of service to the county youth. He has served as the first chairman of Prevention PLUS, the non-profit programs; Kiwanis Club of Forest Park; Citizens Task Force Against Drugs; Arts Clayton; Friends of the Library; Jones Memorial Methodist Church; and the Clayton State College Foundation.

Dougherty CMS

O. Grey Rawls, M.D., of Albany, noted for his excellent service and devoted humanitarianism in the community since 1954, was presented the 1990 Golden Deed Award by the Albany Exchange Club Friday night.

A native of Williamson, Dr. Rawls began practicing surgery after 2 years as a captain in the Army Medical Corps in Korea. He had received his bachelor of arts degree from Emory University and his M.D. Degree from Emory University Medical School in 1946.

Dr. Rawls is an Emory University Hospital Fellow of Surgery and Neoplastic Diseases, a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons, past chief of general surgery at Phoebe Putney Memorial Hospital, and a director of HCA Palmyra Medical Centers. He was the first doctor appointed by the Dougherty County Commission to serve on the Albany-Dougherty County Hospital Authority.

Dr. Rawls was a member of the Georgia Board of Human Resources under Gov. George Busbee, is past president of the Georgia Medical Society, and is a longtime director of the Albany First Federal Savings and Loan Association. He is a member and past chairman of the Board of Deacons at Covenant Presbyterian Church, is a member of the Darton College foundation and is president of the Albany Rotary Club, of which he had been a member since 1958. He is also a quarter horse enthusiast and a pilot.

Medical Association of Georgia

Robert H. Marmer, M.D., team ophthalmologist for the Atlanta Hawks, was recently appointed to the Board of Directors of the American College of Eye Surgery in refractive surgery. He was also given an award "for outstanding contributions to Quality Eye Surgery." Dr. Marmer then traveled to Kuala Lumpur, Malaysia, to instruct a course on Radial Keratotomy Surgery for Asian ophthalmologists. From there he went to Singapore for a meeting of the International

Dr. Robert Marmer

Congress of Ophthalmology where he lectured about Hyperopic Thermal Keratoplasty. He was honored as a finalist for "the most significant original research in ophthalmology."

OTHER NEWS

MAG Impaired Physicians Program

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All contacts held in strict confidence.

John D. Lenton, M.D.
Medical Director
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Ga. WATS 1-800-282-0224

DEATHS

Charles Joel Jr., M.D., of Atlanta, a retired psychiatrist at the Veterans Administration Medical Center in Decatur, died recently of heart disease. He was 69.

Dr. Joel retired after 34 years of service with the VA hospital and became a consultant to the State Department of Human Resources.

He graduated from the University of Georgia and the Medical College of Georgia. After serving in the Navy in World War II, he completed his residency in neurology and internal medicine at New York City Hospital.

Dr. Joel moved to Atlanta in 1950 and began a practice in general medicine, becoming associated with the VA and Emory University hospitals. He also served a fellowship at the Menninger Clinic in Kansas.

Arthur J. Merrill, Sr., M.D., of Atlanta, an internist and nephrologist, died last March at the age of 81.

Dr. Merrill had practiced medicine in Atlanta for more than 50 years. In the early 1950s, he was named director of nephrology at the Emory University School of Medicine, and he became Atlanta's first nephrologist. His pioneering work resulted in his bringing the first dialysis machine to the Southeast in 1951.

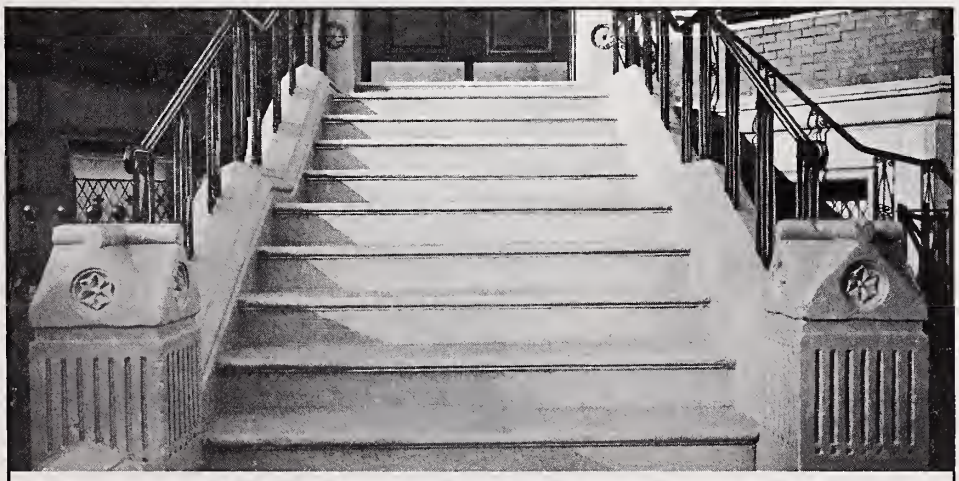
Dr. Merrill graduated in 1952 from the old Atlanta Boys' High School and attended Georgia Tech for 2 years. He transferred to Emory University and graduated in 1930 with a degree in science. He received a degree at the Emory Medical School in 1933.

Dr. Merrill completed his internships and residencies at the Cincinnati General Hospital, the Vanderbilt Hospital and Grady Memorial Hospital and entered private practice in Atlanta in 1940. He joined the faculty at Emory in 1943 and taught until 1962 while continuing his private practice.

The National Kidney Foundation honored him last April 7 at its third annual "Gift of Life Gala" in Atlanta.

Dr. Merrill was a former president of numerous professional organizations, including the American, Southern, and Atlanta Federations for Clinical Research, the American Clinical Society, the Circulation Section of American Heart Association, and the Southeast Clinical Club.

He was associate editor of the *Heart Bulletin* and wrote 47 articles on medical research for various publications. In 1967, Emory presented him its Golden Headed Cane award.



To Anyone Who Has A Lung Disease This Is A Breathtaking View.

Climbing even a short flight of stairs can leave a person who suffers from a chronic lung disease fighting for breath. An estimated one out of ten Americans suffers from chronic lung disease. And the mortality rate from lung diseases is increasing faster than any of the other top ten causes of death.

Until we do something about lung diseases, no one can breathe easy.

It's a matter of life and breath.®

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CALENDAR

July

9-11 — *Kiawah Island, SC:* **10th Annual Clinical Obstetrics.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

12-14 — *Kiawah Island, SC:* **Update in Gynecology.** Category 1 credit. Contact Div. of cont. Ed., MCG, Augusta 3091. PH: 404/721-3967.

16-20 — *Kiawah Island, SC:* **12th Annual Critical Care Medicine.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

23-25 — *Kiawah Island, SC:* **13th Annual Pediatric Update.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

27-29 — *Hilton Head Island, SC:* **Current Financial Strategies — Your Practice and Investments.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

31-Aug 3 — *Atlanta:* **A Comprehensive Board of Review in Internal Medicine in Atlanta.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

August

2-5 — *Hilton Head:* **Georgia Psychiatric Physicians Association.** Category 1 credit. Contact Jim Moffett, GPPA, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535.

13-17 — *Hilton Head, SC:* **Summer Imaging & Interventional Techniques VIII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-26 — *Sea Island:* **Georgia Society of Anesthesiologists.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

September

6-9 — *Ponte Vedra, FL:* **Georgia Thoracic Society** (Tri-State with South Carolina and Florida). Contact Dan Groves, American Lung Association, 2452 Spring St., Smyrna 30080. PH: 404/434-5864.

8 — *Atlanta:* **Congestive Heart Failure.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-13 — *Atlanta:* **Interventional Radiology for Technologists & Nurses.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-14 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

16-18 — *Sea Island:* **Georgia Urological Association.** Contact Dr. T. S. Trulock, Albany Urology, 1950 Palmyra Rd., Albany 31701. PH: 912/883-1503.

17-19 — *Atlanta:* **Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXIV.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-22 — *Sea Island:* **Georgia Surgical Society.** Category 1 credit. Contact William McGarity, M.D., Emory Clinic, 1365 Clifton Rd., Atlanta 30322. PH: 404/321-0111.

21-23 — *Pine Mountain:* **Georgia Chapter, American College of Physicians.** Contact Dr. Robert Copeland, 1550 Doctors Dr., Ste. 301, LaGrange 30240. PH: 404/884-2641.

23-27 — *Sea Island:* **Georgia Obstetrical & Gynecological Society.** Category 1 credit. Contact Chester Lane, 69 Butler St., SE Atlanta 30303. PH: 404/659-0289.

24-25 — *Atlanta:* **Quantitative Thallium Myocardial Tomography.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-28 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-28 — *Savannah:* **14th Annual Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

28 — *Atlanta:* **Recent Advances in Clinical Oncology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

October

1-5 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

ARMY RESERVE MEDICAL PROFILE NO.9

Dr. Holwick outside of hospital where she practices as a civilian traumatologist

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.; University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital; Huntington Memorial Hospital, Pasadena, California; Traumatologist, Arcadia Methodist Hospital, Arcadia, California.

OUTSTANDING ACHIEVEMENTS Borden Freshman Prize; Alpha Lambda Delta; Phi Beta Kappa; Phi Kappa Phi; Bovard Award; ALD Award; American Institute of Chemists Medal Award; Summa Cum Laude, University of California; Alpha Omega Alpha.

"When you enter private practice, the only cases seen are usually those limited to your specialty. Serving as a physician in the Army Reserve offers me a departure from my daily routine. I can be involved in virtually anything I choose. If a certain case interests me, I can ask to be part of the surgical team. If I wish to spend time teaching students, I have that option, too.

"As a Reserve physician, I've had the opportunity to interact with different people, from various backgrounds, with assorted medical and social viewpoints. As a result, I've grown as a physician and as a person.

"I spent six months looking into the Army Reserve program before I joined, wanting to make sure that my skill and time would be put to good use. I've been a Reservist three years now, and I still find it extremely rewarding. I have the satisfaction of knowing that I'm serving my country."

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Dr. Holwick in operating room at Letterman Army Medical Center.

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- *Dosage for adults with active duodenal ulcer is 300 mg once nightly (150 mg b.i.d. is also available)*

References

1. USP DI Update. September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

AXID®
nizatidine capsules

Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

PV 2098 AMP [091289]

Additional information available to the profession on request.

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New Medicaid Rules Go Into Effect

An additional 25,000 Georgians are now eligible to receive Medicaid benefits for the first time. On April 1, legislation increasing Medicaid eligibility went into effect for pregnant women, children under the age of 6 years, and the medically needy, according to the Georgia Hospital Association (GHA).

Hospital leaders report the increase will allow a larger segment of Georgia's poor and uninsured population easier access to medical care. Every day, more than 34,000 people use the services of Georgia's acute care community hospitals for inpatient and outpatient treatment, and one-third of them do not have the resources to pay for health care treatment.

"The state of Georgia has made great strides this year to provide health care to needy Georgians who could not afford routine health care," said Joseph Parker, GHA president. "By increasing Medicaid eligibility, the number of indigent and uninsured patients can be reduced, resulting in less cost shifting to the private sector and private pay patients."

Under the legislation passed this year, Medicaid eligibility for pregnant women and children under the age of 6 years has been expanded to 133 percent of the federal poverty level. Previously, pregnant women and children from a family of four earning over $12,700 a year, or $244.23 a week, were not eligible for Medicaid; the new guidelines increase the poverty level for them to $16,891 a year, or $324.82 per week. GHA estimates that this increase will allow almost 20,000 additional women and children to receive Medicaid assistance for health care.

Additional legislation passed in 1989 that will have a positive impact on the medically needy also went into effect April 1. An estimated 5,300 medically needy aged, blind, and disabled persons will be allowed to "spend down," or subtract actual medical expenses from annual income, to meet Medicaid eligibility requirements.

The expanded eligibility requirements provide more state funding for children and the elderly. "With the new requirements, more pregnant women, children, and medically needy may seek medical care before their medical conditions become life-threatening," Parker said. GHA reports that 17.7 percent (close to one million Georgians) have no health insurance, and many Georgians lack adequate insurance for necessary medical care.

The cost to hospitals for treating uninsured patients is enormous. In 1988, Georgia hospitals' cost for indigent care, bad debt, and charity totaled $581 million. With these losses, approximately 40 percent of Georgia's community hospitals operated at a loss in 1988. Most Georgians are unaware of these losses, however. Only 33 percent of respondents in the recent GHA survey said they knew the state does not pay any of the charges for people who have no insurance and cannot qualify for Medicaid.

Free Hepatitis Vaccines to be Offered to High-Risk Health Workers

Hospitals and other health care providers must offer hepatitis B vaccinations free of charge to all workers who risk being exposed to the disease, according to a recent directive from the Occupational Safety and Health Administration (OSHA). The new requirement is an interim step, designed to protect workers until OSHA develops final regulations next year to limit occupational exposure to blood-borne diseases.

With its latest directive, OSHA clarified a section of the "general duty" clause of the federal law, which requires employers to provide a hazard-free workplace. The agency added the words "free of charge" to its instructions that employers offer the hepatitis B vaccine to employees who risk contact with body fluids.

The American Hospital Association does not oppose the measure, saying it will save hospitals money in the long run. Approximately 12,000 health care workers are infected annually with the hepatitis B virus, and about 200 die, according to estimates from the Centers for Disease Control in Atlanta. The three-shot series of hepatitis B vaccinations costs about $120.

Community Hospitals Closures Exceeded Openings in 1989

Sixty-five U.S. community hospitals in 25 states were shuttered last year, while 12 general medical/surgical hospitals were opened in six states, according to new American Hospital Association (AHA) data. Seven of the 12 hospitals that opened were actually reopenings of facilities that had been closed. Of the 65 hospitals that closed, 16 continue to offer outpatient services.

The 65 community hospital closures compare with 85 in 1988 and 77 in 1987. In all, 508 community hospitals closed during the 1980s, according to the AHA.

Hospitals are being forced to close for a variety of reasons, he said, including inadequate reimbursement, a lack of patients because of population shifts, and the inability to attract and retain physicians. Rural hospitals accounted for 44 of the 65 community hospital closures in 1989, totaling 2,181 licensed beds.

Dear Editor,

I'd like to express my appreciation for the Editor's Corner, "Reflections," in the March issue of the *Journal of the Medical Association of Georgia*.

I was especially taken by your remark, "You may steal my money and regulate my life, but you cannot steal my happiness nor my satisfaction from what I do."

Certainly, we need to keep our eye on that mark.

In spite of what is all around us, I cannot imagine any other profession offering the happiness and satisfaction that is given to us as a natural outcome of our endeavors. Even with change, with administrative encroachments, etc., etc., I do believe anyone is blessed to have the privilege of serving in the medical profession. I must say there are certain days that superficially cause me to doubt this, but when I give it any serious reflection, the anxieties vanish.

Thanks for your "sharing."

Sincerely,
Joseph H. Dimon, III, M.D.
Orthopedic Surgeon, Atlanta

Dear Editor,

I thought your editorial in the March, 1990, Volume 79, issue of MAG was most outstanding. This article entitled "March in January: Reflections in Crystal Balls" was indeed full of important thoughts, and I am glad you were able to share those with us. I think you are an outstanding writer and few have the ability to express themselves in such a forceful way.

Sincerely,
Jeffrey T. Nugent, M.D.
Orthopedic Surgeon, Atlanta

Dear Editor,

Just a note to tell you how much I appreciate your editorial in the March issue entitled "Reflections." You phrased very thoughtfully and very well many of the concerns that some of us "older" doctors have in the rapid pace toward commercialization of what we have always considered a profession.

One definition of a profession is that it is an occupation whose rewards are not primarily financial and in which the success is not proportional to the income. In other words, I think that financial considerations should definitely be secondary to be a true profession. Obviously this definition is hardly applicable to many of our legal friends.

To the extent that we can maintain a primary concern with the ethics of a profession devoted to people and avoid the concept that a surgeon is a skilled technician, we would be far better off. It may be a rear guard action but it has certainly been my view that it is certainly worth fighting for.

You phrased very well. As a father of a daughter recently beginning practice, I have concerns for the future of medicine that are selfish without involving my own personal welfare.

Again, I appreciate your thoughts with which I agree so completely.

Sincerely,
F. James Funk, Jr., M.D.
Orthopedic Surgeon, Atlanta

QUOTES

Success listens only to applause — to all else it is deaf.
ELIAS CANETTI

Men of sense in all ages abhor those customs which treat us only as the vassals of your sex.
ABIGAIL ADAMS: *Letter to John Adams,* March 31, 1776

Woman is stronger by reason of her feelings than man by reason of his strength.
FRENCH PROVERB

Between knowledge of what really exists and ignorance of what does not exist lies the domain of opinion. It is more obscure than knowledge, but clearer than ignorance.
PLATO: *The Republic,* V, *c.* 370 B.C.

My grief lies all within; And these external manners of laments Are merely shadows to the unseen grief That swells with silence in the tortur'd soul.
SHAKESPEARE: *Richard II,* IV

Hearts are not had as a gift but hearts are earned . . .
WILLIAM BUTLER YEATS

Eloquence
That might have soothed a tiger's rage, Or thawed the cold heart of a conqueror.
P. B. SHELLEY: *Queen Mab,* I, 1813

Great and small have the same accidents, and the same vexations, and the same passions; but one is at the circumference of the wheel, and the other near the center, and thus less agitated by the same movements.
BLAISE PASCAL: *Pensées,* VIII, 1670

In many ways doth the full heart reveal The presence of the love it would conceal.
SAMUEL TAYLOR COLERIDGE

Of Summer and Pleasure and Revisiting the Past

Every now and then go away, have a little relaxation, for when you come back to your work your judgement will be surer, since to remain constantly at work will cause you to lose power of judgement . . . go some distance away, because then the work appears smaller and more of it can be taken in at a glance and a lack of harmony and proportion is more readily seen.

LEONARDO DA VINCI

We are all of us compelled to read for profit, party for contacts, lunch for contracts, bowl for unity, drive for mileage, gamble for charity, go out for the evening for the greater glory of the municipality, and stay home for the weekend to rebuild the house. Minutes, hours, and days have been spared us. The prospect of filling them with the pleasures for which they were spared us has somehow come to seem meaningless, meaningless enough to drive some of us to drink and some of us to doctors, and all of us to the satisfactions of an insatiate industry. In a contrary and perhaps rather cruel way, the twentieth century has relieved us of labor without at the same time relieving us of the conviction that only labor is meaningful. . . . We are vaguely aware that an uncorrupted pleasure awaits us somewhere, if we can only learn to forgive ourselves for taking it; we sense that the taking is both possible and desirable. . . . It is probable that our very awareness of the existence of pleasures that we are either postponing or denying ourselves adds to the tensions induced by unrelieved labor. We feel guilty when we take our pleasure, because there is so much work we might do. We feel guilty when we work so hard because our lives may depend upon pausing for pleasure. The two guilts are incompatible, and we suffer further from the head of steam their mutual abrasiveness builds up. Still, there is always hope of resolving the dilemma; the life line may be badly snarled, but it has not been permanently cut. . . . It is almost as though the twentieth century had been engaged in a long struggle to produce a new kind of man — a man whose sole concern should be his useful work — and, in our children, had successfully accomplished the mutation.

The Decline of Pleasure
WALTER KERR

"Something new was there now. They had been replaced by the memories jaded by time and softened by age. Those bass of years past grew ever larger nourished by the nutrients of gentle memories."

We saw Bill first as the boat slid quietly through early morning fog blanketing the Homosassa River and headed upstream to MacRae's Dock. He looked about the same as when we last saw him. A bit more thin from the recent encounter with a surgeon. His gallbladder had "busted" 2 days following the first

of two visits to the physician in the little fishing village who told him he had the flu.

"Medicine is tough," I said to him. "We can't always be right."

"Well, I daren't not blame him. I got home from the hospital in only 17 days." Bill was always understanding. Bill's different from Barney. That's his younger brother, Barney Trotter. He grew up on the River as did Bill. They both grew to manhood and now spend their adult lives as fishing guides. Spend their lives teaching those of us with lesser intuition the ways of God's lesser creation, the fish. That's about all they know, the River and boats, fishing and hunting, women and drinking. That's enough though, you see, if you know all there is to know about all that.

We had gone back to this long revered fishing spot as we had so many times through the years. There was an air of expectancy that the river would yet possess those magical qualities, would exist as we had first found it so long ago. The trip in years now long past had always been made with men only. Now, however, it was the four of us and our wives.

"I want to see it for myself," she had said, or implied with meaning. "I want to see the river, and I want to meet Bill and Barney. I have heard so much about them."

I shuddered. The language, the profanity, the description of escapades too erotic to recount. "Are you sure?," I said. It was too late now. The planning had all been done. We were all off to the river, the four of us were, and this time with wives. I prayed for temperance and moderation in Bill's language and in Barney's consumptive habits.

We left the boat dock early the first morning heading out to the flats. The river awakens slowly. Boats of all dimensions crowd in upon the channel as we head downstream. Green to port and red to starboard. So different now from those early days. Canals dug into the once pristine marshland. Houses, second homes, boat docks, swimming pools — they are all crowded in upon our wild isolation of past years.

"No fishing here," Bill says. "Gotta go further out." The bass were gone from the river now. The canals, the developments, the pollution, the relentless drive to grow had sent them elsewhere.

Progress seems such a fickle mistress. She lures us from the present, however satisfying, to an uncertain future. Surely change is an integral part of our world, but why did change have to come to our river? Why did all of these people have to build all of these houses, dig all of these canals, put in all of these swimming pools and tennis courts? Why couldn't they leave Bill and Barney and our river alone?

Summertime comes to us again, and once again the decision of what to do with it crowds in upon us. The brochures, the planned trips, the varied enticements — beaches and mountains, tours and cruises. Some tell us that it is best spent, a vacation, at home. "Why bother," they say, "with all of the planning? Besides, it costs less." I envy them. They spend less time agonizing over travel folders. Their liquid assets are more liquid than mine as a result.

But we, we had returned as swallows to Capistrano, as Monarch butterflies to the cedars of the California coast. We had come again to the Homosassa River. Somehow, though knowing different, we had come to find again, to recapture, the magic of years past. Had come to find the large mouth bass and the unspoiled river. To find the fiesty Bill Trotter and the yet sobering up Barney. They were gone now. Gone as with the morning mist of the river. Something new was there now. They had been replaced by the memories jaded by time and softened by age. Those bass of years past grew ever larger nourished by the nutrients of gentle memories. Bill was Errol Flynn. Barney was F. Scott Fitzgerald. And we, why we were Hemmingway pounding the bar for another brandy and pulling in another Goliath.

Oh, come again to me, ye seductive goddess. Ye summertime. Come back to me, ye brochures and travel folders. Soothe my harried and work worn brow with the cool balm of idyllic ocean breezes. Lay quietly upon my restless spirit the calmness of your fetid imagination. Loose the restraints of these past labor intensive days and let the mist of the river paint pictures of bass too large to describe. Oh, Bill and Barney Trotter, why must you grow old? But, must you do so, oh, come to me, sweet summertime.

CRU

"Or Would You Rather Be a Sheep?"

Frank E. Carlton, M.D.

"I believe physicians are only advocates insofar as they are priests practicing in the holy temple of medicine, not to be questionned. . . ."

When seriously threatened, man has tended to express his deepest feelings through laughter or tears; laughter at times being healthy and desirable and tears certainly appropriate at other times in our lives. The tears and/or laughter generally come before we have decided what we are going to do, if we are going to do something, and how we are going to do it.

Since January 1, 1989, physicians in Georgia have been severely threatened. Some of us have laughed, some of us have cried, some of us have done both. But more importantly, all too many of us have not decided if (or what) we are going to do.

Why? Why should one of the most intelligent, best educated groups of professionals in the world have such difficulty in dealing with what is arguably one of the worst financial threats they have faced or will face in their entire lives? It is not a matter of whether or not they will do the right thing or whether or not they will persevere to a satisfactory conclusion. For the majority, it is a question of whether they will do anything at all.

When I became president of the Georgia Medical Society I was largely motivated by the fact that I had been solicited by my friends to take on the job. Underneath that consideration was my pride in being a physician. All my life I had believed that doctors were good human beings, honest and well intentioned people who contributed something worthwhile to society. One of my ambitions from childhood was to be a part of that group as I imagined them to be.

Well, things change. I still want to be a physician but my fantasies about how we look to the public and how we are in our secret hearts has been modified. When reality alters fantasy there is almost always some degree of disillusionment. When one is first in love and enters upon a honeymoon, one never considers that all honeymoons must end. In the last few months my honeymoon with medicine has ended. AEtna, HCFA, Medicare, MAG, the GMS, my fellow physicians, and some recognitions about myself have forced some new realities upon me and therefore some disillusionment.

Although I still believe that most doctors are intelligent, well intentioned, hard working people, I also believe by and large that we are a bunch of sheep. I believe physicians are only advocates insofar as they are

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"We are so caught up in chasing our old-fashioned image that the real world has left us behind."

priests practicing in the holy temple of medicine, not to be questioned by mere untutored mortals, but when it comes to the fire of the financial world, or hard-nosed politics, or fighting bureaucrats who have decided that they are going to remake the practice of medicine, we behave in a different fashion.

The majority of physicians, as well as their anachronistic representative bodies, are essentially a bunch of narrow, unresponsive wooly headed beasts, subject to being led by any surge in the crowd. We are so caught up in chasing our old-fashioned image that the real world has left us behind. I venture to say that a high percentage of physicians are not really acquainted with the financial details of their own lives. They simply collect a check, sign a tax form at the end of the year, and are dimly aware that their spouses and children have too many credit cards.

Are we as physicians shouldering the social part of our professional responsibilities? Are we reactive? Do we even vote? Do we defend our inalienable rights as defined by those radical revolutionaries that founded this country?

An excellent case in point for this thesis is the recent statewide questionnaire sent out by the Medical Association of Georgia to solicit data on how widespread the fundamental problems with AEtna/Medicare were throughout the state. The questionnaire was sent to some 7000 physicians and the staff at MAG had to struggle to get 1500 answers back!

Case closed.

I would simply ask you, my brother physicians, if this cause will not unite us and will not bring a demonstrable majority into the trenches, what will it take? There are some things that we can do together in our organized representative bodies, like the GMS and MAG, and there are some things we must do as individuals. I personally think it is time for each of us, myself included, to consider very seriously what it is we are going to do. How far we intend to carry our efforts and when we are going to start.

. . . Or as the song goes, "Would you rather be a sheep?" ■

Determinants of Primary Therapy of Early Stage Breast Cancer

Charles M. Ferguson, M.D., Arthur C. Feinstein, M.D., William J. Pendergrast, M.D.

Abstract

Controversy exists in the local treatment of early stage breast cancer. In an effort to determine what criteria are used in selection of therapy for patients with breast cancer, we reviewed the experience of early stage breast cancer at Crawford Long Hospital of Emory University during 1986 and 1987.

One hundred eighty-three patients were identified with Stage 0, I, or II breast cancer. A total of 11% of patients were treated by lumpectomy and radiotherapy. Residence distant from the hospital was associated with a low rate of utilization of lumpectomy and radiotherapy ($p = .05$). The strongest predictor of therapy was the surgeon involved in the patient's care ($p = 0.001$). For surgeons who cared for five or more patients with breast cancer over this time period, rates of utilization of lumpectomy and radiotherapy ranged from 0 to 20% of patients.

The results of this study suggest that the surgeon consulted is the major determinant of the type of therapy used in the primary management of breast cancer.

Introduction

There continues to be considerable controversy regarding the optimum primary therapy of early stage breast cancer. Mastectomy has been well accepted as local therapy of Stage 0, I, and II carcinoma of the breast, and until recently was widely accepted as optimal therapy. Several recent prospective controlled trials comparing lumpectomy and breast irradiation to mastectomy have revealed equivalent survival rates.[1-4] These trials confirmed numerous previous retro spective trials,[5-7] resulting in the acceptance of lumpectomy and radiotherapy as an alternative to mastectomy in early stage breast cancer.

Despite the data suggesting equivalency of these therapies, the utilization of lumpectomy and radiotherapy is still considerably less than that of mastectomy. There are several factors which might make lumpectomy and radiotherapy less advisable than mastectomy in individual patients. Such factors include age of the patient, inconvenience of radiotherapy, cost of radiotherapy, the presence of diffuse intraductal carcinoma associated with the invasive carcinoma, and size of the primary tumor.[8] In addition, there are certainly psychologic factors which play a part in a patient's decision for radiotherapy.

This study is a review of recent experience in the management of early stage breast cancer at Crawford Long Hospital in Atlanta in an

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It is clear from this series that there is a significant difference in the treatment that a patient received for early stage breast cancer based on which surgeon was consulted.

attempt to elucidate factors determining selection of therapy.

Methods

The tumor registry abstracts of all patients with Stage 0, I, or II breast cancer treated at Crawford Long Hospital of Emory University in Atlanta between January 1, 1986, and December 31, 1987 were reviewed. Patients were categorized according to therapy into two groups: mastectomy (Mast), including simple, total, modified radical, and radical mastectomy; and lumpectomy and radiotherapy (LR), including any type of tumor excision plus radiotherapy, regardless of therapy to lymph nodes. These groups were compared with regards to age, race, stage of tumor, whether or not the patient lived distant to the hospital (outside the metropolitan Atlanta area), and the surgeon involved in the patient's care. Statistical analyses were performed using students T-test and χ^2 analysis.

A simple questionnaire was sent to each surgeon caring for five or more breast cancer patients during this time period. The questionnaire asked what therapy the surgeon felt was best for Stage I carcinoma and for Stage II (T2) carcinoma. It also asked whether the surgeon discussed or recommended LR always, often, seldom, or never. It asked whether patients requested or refused LR always, often, seldom, or never. Additional narrative comments were requested. Results of this questionnaire were compared to actual practices.

Results

A total of 183 patients with Stage 0, I, and II breast cancer treated at Crawford Long Hospital during 1986 and 1987 were identified. Three of these patients received no definitive therapy at Crawford Long Hospital and are not considered further. Nineteen of the 180 treated patients were treated by lumpectomy and radiotherapy (11%), while the remaining 161 patients were treated by some form of mastectomy. None of the patients with Stage 0 carcinoma were treated with LR. Eleven patients were found to have lobular in situ carcinoma. Two were treated by local excision alone, two by bilateral mastectomy, and seven by modified mastectomy. Eleven patients with intraductal carcinoma were treated by modified radical mastectomy. Seven of 82 (9%) Stage I and 12 of 76 (16%) Stage II carcinoma patients were treated with lumpectomy and radiotherapy. These differences between stages do not reach statistical significance ($p = 0.1$). There was no difference with regard to mean age in the two groups (Mast 58 ± 14, LR 54 ± 17, $p > 0.05$), nor in race (43 of 158 Mast patients were black, 11 of 19 LR patients were black, $p > 0.05$).

Thirty-five of the 161 Mast patients (22%) lived distant from the hospital, while none of the 19 LR patients lived outside the metropolitan area. This difference was significant at the 0.05 level.

TABLE 1 — Type of Primary Therapy, By Surgeon

Surgeon	*Mastectomy*	*Lumpectomy and Radiotherapy*
1	62	2
2	21	0
3	11	1
4	7	0
5	5	1
6	5	1
7	4	1
8	5	0
9 (Pool of 17 Surgeons)	24	14

The rate of utilization of LR for Stage I and II breast cancer varied widely among the various surgeons (Table 1). For surgeons caring for five or more breast cancer patients over this time period, the utilization of LR varied from 0 to 20%. The pool of 17 surgeons caring for less than five patients utilized LR 35% of the time. This difference in utilization of LR between surgeons is statistically significant at $p = 0.001$ (χ^2).

Results of the questionnaire suggest that all surgeons felt that LR and Mast were equivalent therapies for patients with Stage I disease, and three of seven responding surgeons felt it was equivalent for Stage II (T2) breast cancer. All surgeons

stated they always discuss LR as an alternative therapy to mastectomy, and five of the seven stated they often recommended LR to patients, but five of the seven surgeons stated that patients often refuse LR. The only answer on the questionnaire predictive of utilization of LR was if the surgeon stated patients seldom or never refused LR ($p = 0.05$). Patients' request for LR, as reported by the surgeon, was not predictive of LR.

Discussion

Numerous retrospective and prospective studies suggest that lumpectomy and radiotherapy is equivalent to mastectomy in terms of 5-year survival for early stage breast cancer.[1-7] As noted by our questionnaire, LR has become intellectually accepted by practicing surgeons as adequate therapy for Stage I breast cancer. Despite this acceptance of LR for early stage breast cancer and numerous publications advocating its use, there are little data available documenting numbers of patients actually treated by LR rather than mastectomy. Recent data from NSABP trials suggests LR is used 30-40% of the time for Stage I carcinoma in participating hospitals.[9, 10] Similarly, in a recent poll, 53% of Ohio surgeons indicated that LR was their preferred therapy for Stage I breast cancer.[11] Though there are several factors, both biologic and social, which may aid in the decision making process of therapy for an individual patient, it is our impression, based on discussions with physicians from other parts of the United States, that the rate of utilization of LR seems to vary by geographic location. This study was an attempt to identify factors related to selection of LR as primary therapy for early stage breast cancer.

In several published studies, the presence of an extensive intraductal carcinoma associated with an infiltrating ductal carcinoma and the presence of a positive resection margin in the lumpectomy specimen are associated with high rates of local recurrence following LR.[12, 13] Thus, either of these pathologic findings are considered relative contraindications to LR. Unfortunately, we were unable to obtain pathology reports on all biopsies in this series, many of which were performed at other facilities, and thus we were unable to address this issue. However, as the percentage of patients with such poor prognostic factors at the JCRT appears to be at most 35%,[14] it seems unlikely this could account for the low utilization of LR in this series. Other pathologic features considered to have a possible effect on local recurrence are tumor grade and local lymphatic invasion, though these are not well established.

Age might be expected to relate to utilization of LR. Though age less than 30 years has been shown by some investigators to be associated with increased local recurrence following LR,[15, 16] this has not been substantiated by most series. As the major advantage of LR is cosmetic, one might expect younger patients to favor LR. Similarly, many older patients might be unwilling to make the numerous trips to radiotherapy for LR and thus opt for mastectomy. It is thus interesting that we could find no statistical relationship between age and utilization of LR. Other investigators have also failed to show any relationship between age and selection of LR as primary therapy of early stage breast cancer.[17, 18]

As LR requires 5-6 weeks of daily out-patient visits to complete radiotherapy, one might expect that those patients who live distant from a dedicated radiotherapy unit would be less likely to undergo LR. This was found in this series, in that none of the patients from outside of the Atlanta metropolitan area were treated with LR ($p = 0.05$).

Similarly, cost might be considered a relative factor in decision making. In a review of 79 patients with Stage I or II breast cancer treated in New York during 1983 and 1984, it was found that total costs for LR were approximately 30% higher than those for mastectomy.[19] Of note, surgeon 1 in this series, who cared for the largest number of breast cancer patients and had a low rate of utilization of LR (3%), stated on the questionnaire that he considered cost a relative contraindication to LR.

Despite the data suggesting equivalency of these therapies, the utilization of lumpectomy and radiotherapy is still considerably less than that of mastectomy.

Finally, patient and physician desires must impact on the decision of primary therapy of breast cancer. It is clear from this series that there is a significant difference in the treatment that a patient received for early stage breast cancer based on which surgeon was consulted. Unanswered is whether this difference is due to an unmeasured difference in patient population or in a difference in communication by the individual surgeons.

There is a widely held perception that patients who desire LR are younger and less conventional than those treated by mastectomy. Though data are limited, the information available suggests that patients treated by LR are similar to mastectomy patients in terms of age, sophistication in health care mat-

ters, occupation, sexual activity, and lifestyle.[18, 20, 21] Similarly, in a psychologic study of 31 patients with early stage breast cancer, no clear cut difference in the decision-making process could be shown between mastectomy and LR patients.[22] Perhaps surprisingly, there appears to be little difference between LR patients and mastectomy patients in terms of anxiety, depression, body satisfaction, social and sexual adaptability, or self-esteem.[23] LR patients have been shown to be more concerned about their appearance in pre-op interviews,[17] and more open about their feelings in discussions regarding their breast cancer.[24] In sum, it seems rather unlikely that unmeasured differences in patient populations account for differences in utilization of LR by the various surgeons involved in this study.

Thus, it appears that the difference in utilization of LR by various surgeons is related to differences in surgeon/patient communication. As all surgeons felt LR is adequate therapy for Stage I breast cancer, but those who rarely utilized LR stated their patients often refused LR, there must be some difference between surgeons in how they inform patients about alternatives in treatment. This is an area which deserves further investigation.

Summary

The care of 183 patients with early stage breast cancer was reviewed. None of the 22 Stage 0 carcinoma patients were treated by lumpectomy and radiotherapy. Seven of 82 Stage I and 12 of 76 Stage II patients were treated with lumpectomy and radiotherapy. There was no difference in mean age between the two groups, nor in race. Patients treated with lumpectomy and radiotherapy were less likely to live distant from the hospital. The rate of utilization of lumpectomy and radiotherapy varied widely between surgeons, and the surgeon responsible for the patients care was a statistically significant predictor of lumpectomy and radiotherapy ($p = 0.001$). Based on a questionnaire answered by the individual surgeons, all surgeons felt lumpectomy and radiotherapy was equivalent to mastectomy for Stage I carcinoma. All surgeons stated they discussed lumpectomy and radiotherapy with patients. The surgeons who did not use lumpectomy and radiotherapy stated their patients often refuse it. It appears that differences in communication with patients accounts for differences in utilization of lumpectomy and radiotherapy between surgeons.

Several recent prospective controlled trials comparing lumpectomy and breast irradiation to mastectomy have revealed equivalent survival rates.

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Conservative Surgery and Definitive Radiation Therapy for Early Breast Cancer

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Abstract

Fifty-six patients with clinical Stage I and II breast cancer were treated at Crawford Long Hospital of Emory University with conservative surgery and definitive radiation therapy between the years 1978-1987. All patients had pathologic examination of their lymph nodes except for four patients who had their axillae clinically staged only. All patients received definitive radiation therapy with doses in the range of 45-60 Grays. Boost to the site of the primary was done by electrons, and 10-20 Grays were given. Overall actuarial 5-year survival was 77.8% and disease-free survivals were 69.1% and 64.5% at 5 and 7 years respectively. The actuarial survival for Stage I patients was 77.6% at 5 years with a disease-free survival of 71.1% at 5 years. For Stage II patients, it was 78.7%, with a disease-free survival of 66.3% at 5 years. The most common complication was asymptomatic apical pulmonary fibrosis in 3/50 patients. The overall complication rate was 9%.

Introduction

Over the past 10 years, conservative surgery and radiation therapy have been increasingly employed as a method of treatment for patients with early breast cancer. The widespread use of this treatment technique was brought about by the good tumor control and cosmetic results demonstrated in several prospective and retrospective studies.[1, 4-6, 10, 11] These studies yielded survival rates comparable to those seen in patients undergoing radical and modified mastectomies. Other than the obvious cosmetic advantage of having the breast intact, one must take into consideration the important emotional consequence of losing a breast. This is manifested in improved patient adjustment with conservative procedures.[3] A study of past experience with such conservative therapy given to breast cancer patients treated at The Radiation Therapy Center at Crawford Long Hospital of Emory University is presented.

Patients and Methods

From 1978 to 1987, 56 breast cancer patients were treated by conservative surgical procedures and definitive radiation therapy at Crawford Long Hospital of Emory University in Atlanta. All patients had a lumpectomy and axillary dissection except for four patients who had a lumpectomy alone due to advanced age. The mean age was 52 years, ranging from 30 to 85 years. Of these 56 patients, 33 had clinical Stage I, and 23 had clinical Stage II disease.

All patients received definitive radiation therapy to the breast and, in some cases, to the supraclavicular and internal mammary area. Axillary irradiation with a supplemental posterior axillary field was generally used when lymph nodes were positive and if an axillary dissection was not attempted. The dose to the breast ranged from 45-60 Gy delivered through tangential fields with a Cobalt 60 unit or 10 MEV linear accelerator in daily fractions of 180 cGy per day (with the exception of 5 patients who received 200 cGy per fraction) for 5 days a week. The peripheral lymphatics, when treated, received 45-50 Gy in 180 cGy per fraction by Cobalt 60, 5 days a week.

Three more recent patients received 36 Gy to the internal mammary region by Cobalt 60 and the

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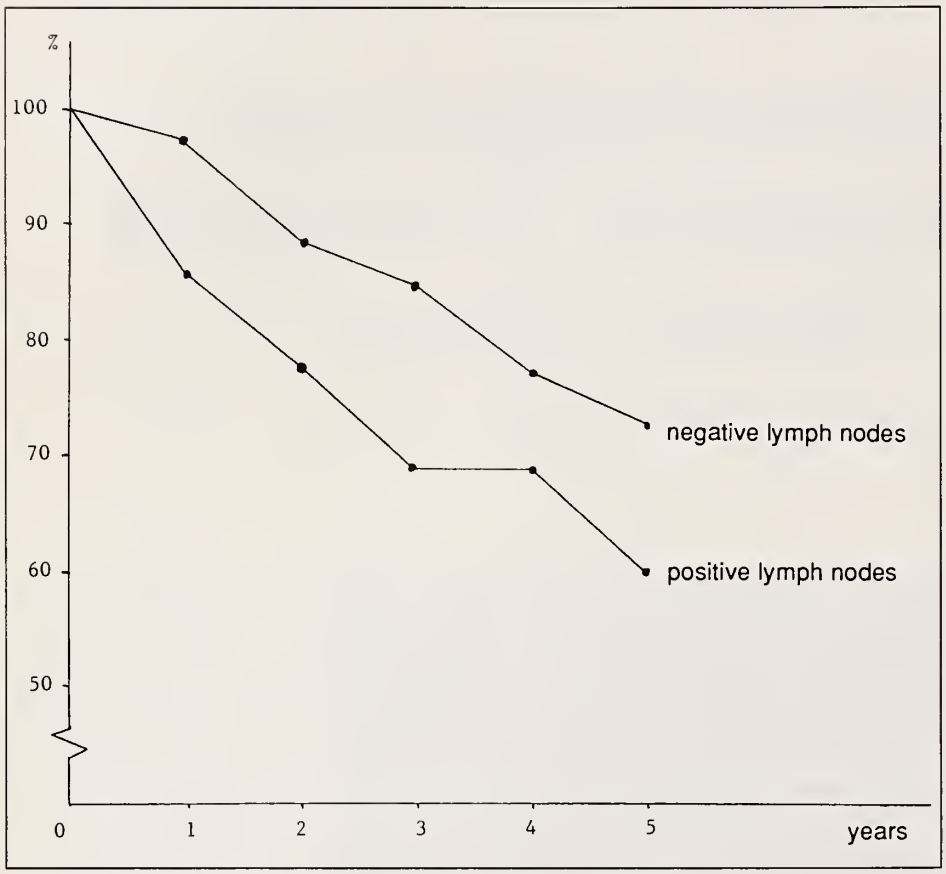

Figure 1 — 5 Year Disease-free survival according to lymph nodal status

remaining 14 Gy by 12 MEV electrons. A boost to the site of the primary was given by electrons in all but two more recently treated patients. The boost dose ranged from 10-20 GY delivered with an energy of 5-12 MEV depending on the breast thickness and the depth and position of the site of the primary. Eleven patients with positive nodes or with no axillary disease received adjuvant chemotherapy in the form of Cytoxan, 5-Fluorouracil, and Methotrexate.

The incidence of bilaterality, previous estrogen therapy and second primaries in all patients was 7%. In 14% of cases a positive family history on the maternal side was noted. The patients had an average follow-up period of approximately 5 years (4 years and 11.5 months) and a range of follow-up between 24 and 105 months.

Axillary irradiation with a supplemental posterior axillary field was generally used when lymph nodes were positive and if an axillary dissection was not attempted.

Results

The overall actuarial survival calculated by life table method[9] was 77.8% at 5 years and 64.9% at 7 years. The effect of lymph nodal status and stage on survival was studied. However, the effect of grade and estrogen and progesterone receptors could not be studied due to the unavailability of sufficient information on grade of the tumor in 37.5% of cases and lack of data on estrogen receptor status in 39% of cases.

In the 52 patients with lymph nodes available for examination, negative nodal status was confirmed pathologically in 38 patients (73%) and positive infiltration was found in 14 patients (27%). The actuarial survival for patients with pathologically confirmed negative nodes was 83.3% at 5 years, with disease-free survival of 73%. For those with pathologically positive nodes, however, it was 66% at 5 years, with the disease-free survival of 60% (Figure 1).

The effect of the stage of the disease on survival was seen in the 77.6% 5-year survival in those with Stage I disease versus a 78.7% overall survival for those with Stage II disease. Five-year disease-free survivals were found to be 71% and 66.3% for Stage I and II, respectively (Figure 2).

Of the six deaths that have occurred so far, only two are due to the breast cancer and the remaining deaths are due to unrelated causes. Only one local recurrence was observed. The patient had a Stage II highly anaplastic tumor. In seven cases, distant metastases in the absence of local recurrence occurred, with bone metastases being the most common primary site of metastases (4/7).

Complications as a result of the treatment given were observed in five of the 56 treated patients (9%) (Table 1).

Discussion

The National Cancer Institute of the Milan study of 1981 where patients with clinically negative nodes and tumors less than 2 cm in diameter were studied showed no difference in disease-free survival or

Table 1 — Complications Due to Radiation Therapy

	Number
Arm Edema	1
Breast edema	1
Asymptomatic pulmonary apical fibrosis	3
Rib fractures	0
Pericarditis	0
Pleural effusion	0
Brachial plexus injury	0
Soft tissue necrosis	0
TOTAL	5 (9%)

overall survival at 7 years between patients treated with Halsted radical mastectomy and those undergoing quadrantectomy and radiation.[12] These results challenged the results of Guy's hospital's[2] previous trial which had shown that there was a higher incidence of local and distant recurrence in patients treated by wide local excision and radiation therapy.

Later came the National Adjuvant Breast Project study[7, 8] with results supporting the use of conservative surgery and radiation therapy due to the comparable disease-free, distant disease-free and overall survival at 5 and 10 years. Thus, Fisher, et al [7, 8] concluded that segmental mastectomy, followed by breast irradiation, is appropriate therapy for patients with Stage I and II breast tumors (less than or equal to 4 cm). They noted, however, that this was true provided that the margins of the respected specimens were free of tumor and that the patients with positive lymph nodes received chemotherapy.

The results presented in this study confirm the effectiveness of conservative surgery and definitive irradiation in the treatment of Stage I and II breast cancer. Although the total number of patients in this study is small the extremely high local control rate (98%) is confirmatory evidence for the efficacy of conservative treatment.

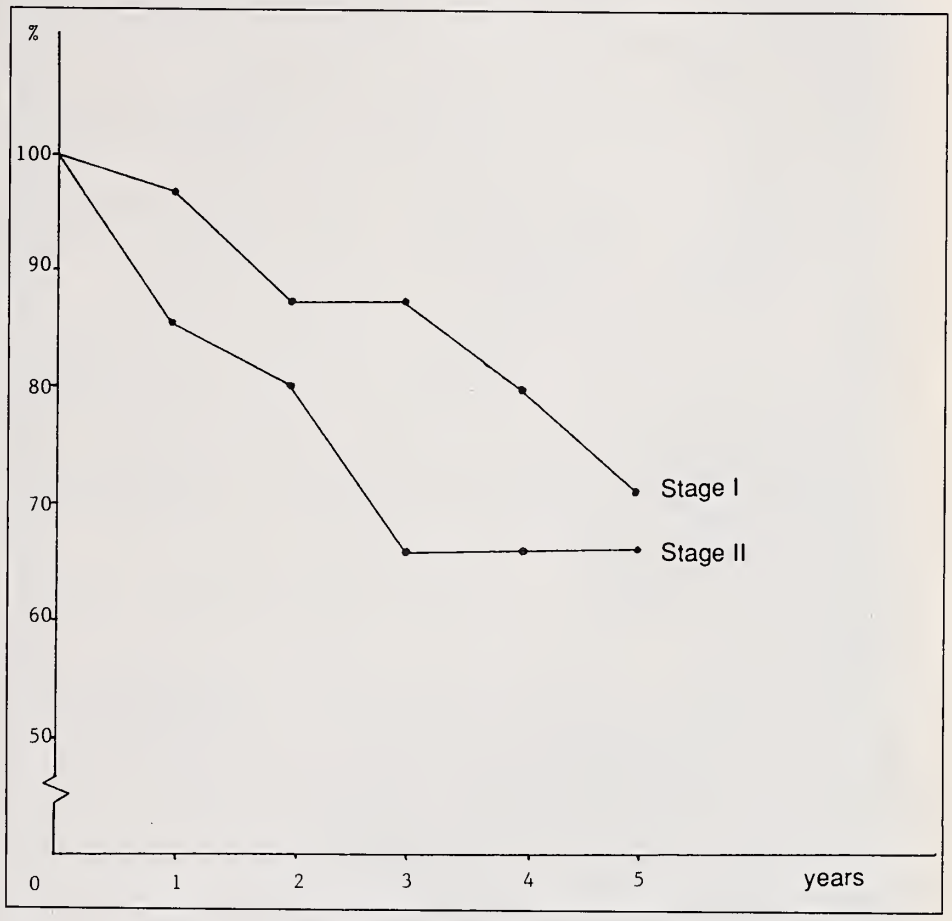

Figure 2 — 5 Year Disease-free survival according to stage

The actuarial survival for patients with pathologically confirmed negative nodes was 83.3% at 5 years, with disease-free survival of 73%.

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A Review of Mammography

Eyvin P. Rasmussen, M.D., William A. Barber, M.D., Connie Duran, R.T.

Historical Perspective

Dr. Robert Egan of Emory University has been called the "Father of Mammography" and rightly so. Other radiologists before him actually experimented with soft tissue radiography of the breast. However, inconsistent results caused most to abandon the technique. In 1956, Dr. Egan was a diagnostic radiologist at the M.D. Anderson Tumor Institute in Houston and was challenged to try mammography by Dr. Gilbert Fletcher (then well known radiation "therapist" oncologist), who also at that time was chairman of the Department of Radiology at M.D. Anderson.

Dr. Egan soon learned that in the radiology literature there were no effective x-ray techniques to obtain consistent diagnostic images. After multiple experiments, a good reproducible technique was found utilizing low KVP (28), high MAS (milliampere-seconds) and industrial fine grain emulsion film.

In 1960, Dr. Egan published his results: "Experience With Mammography in a Tumor Institution." Thus, modern mammography was born or reborn in the late 50s and early 60s.

Preoperative mammography will be positive in approximately 85% of breast cancers. Thus, a woman must not be lured into a false sense of security by a negative screening mammogram without an accompanying physical exam.

In 1963, Dr. Egan moved to Atlanta and has been at Emory University ever since, until his very recent retirement. At Emory, Dr. James V. Rogers (radiologist) and Dr. Waldo Powell (surgeon) had already been utilizing the "Egan" technique for mammography and the world's first "Breast Imaging Center" was born at Emory in 1964.

Dr. Egan also has to his credit multiple articles, 13 monographs on mammography, and his most recent book *Breast Imaging, Diagnosis and Morphology of Breast Diseases.* He has always stressed the "team approach" to detection and treatment of breast diseases.

Dr. Marjorie McSweeney-Kossoff also should be noted at this time. She has worked with Dr. Egan for many years at Emory and contributed greatly to teaching and research in mammography and breast sonography.

In the 1960s, several large studies showed mammography to be of value. However, many radiologists had difficulty obtaining good technical films and many surgeons and radiologists were disappointed in the results. In the 1970s, "dedicated" x-ray machines for mammography were introduced; also film and film-screen combinations were markedly improved. Radiation scares surfaced in the late seventies and again slowed progress in the field.

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Processor variability is recognized as one of the most important reasons for poor image quality and resultant higher radiation dose. Equipment must be monitored and adjusted frequently.

Xerography of the breast became widely utilized in the 1970s. Many thought the technique superior to film-screen mammography because of its improved penetration and visualization of the chest wall as well as the entire breast in the lateral view. In xerography, a latent image is formed using x-rays and a selenium plate instead of film for the image production. A permanent image is produced on opaque paper by a dry development process. Edge enhancement and wide exposure lattitude are also advantages.

Disadvantages include a larger radiation dose to the breast with xerography; higher kilovoltage also delivers more scattered radiation to the rest of the body. Higher kilovoltage diminishes differences in mammographic density which in many cases is detrimental to analysis and diagnosis. In many cases, xerography yields less resolution and very fine calcifications may not be resolved. Image artifacts are also more common than with film-screen mammography.

Because disadvantages seem to outweigh advantages, most serious investigators have concluded that film-screen mammography is the preferred method of imaging the breast.

Early Studies

The Health Insurance Plan of Greater New York City (HIP Study).

A well controlled, randomized study was started in the early 60s included 64,000 women. After 5 years, there was a 30% decrease in mortality due to breast cancer in the screened group as compared to the controls. This benefit was only demonstrated in women over 50. Dr. Egan was a consultant to the study. According to him, the quality of some of the mammograms was "barely tolerable." Yet, as noted above, a significant impact on breast cancer could be made, even with relatively primitive equipment and minimal experience.

Breast Cancer Detection Demonstration Project (BCDDP).

Starting in 1973, each of 27 communities were to screen 10,000 women volunteers. Each woman was to have a yearly physical exam of the breast as well as a yearly mammogram for 5 years. Asymptomatic women over age 35 were eligible. Unfortunately, a radiation scare in 1975-76 reduced the number of women who completed all five exams. However, survival rates are still very impressive. (Baker 1982)

Emory University and Georgia Baptist Medical Center participated in the BCDDP and of 82 cancers detected by mammography alone (non-palpable), there was a 97.6% 10-year survival rate (combined results).

Recent papers in the literature suggest that breast cancer mortality can be reduced by 50% in women who participate in regular screening by mammography and regular physical exams. (TABAR)

In a recent review, 220 nonpalpable breast cancers were detected by mammography. In approximately 16,000 women, 115 cases (56%) were found to be noninvasive. Of 90 invasive nonpalpable cancers, only 7% had axillary nodes positive for metastasis. This same institution reports a positive predictive value (PPV) of 20% for mammography. (Silverstein)

Positive predictive value (PPV) defined: if 100 mammograms are called suspicious for cancer and if biopsy of all 100 cases yields 15 cancers, the PPV is 15%. At our own institution, we have found a PPV of 36% for non-palpable lesions.

What are the current capabilities and limitations of mammography? Preoperative mammography will be positive in approximately 85% of breast cancers. Thus, there is a significant percentage (15%) of cancers that cannot be detected by mammography. A woman must not be lured into a false sense of security by a negative screening mammogram alone. Physical exam by a physician and breast self exam are essential parts of breast cancer detection. However, as noted above, large numbers of non-palpable early tumors can be discovered mammographically.

The two major types of breast cancer are ductal carcinoma (90%) and lobular carcinoma (10%). Lobular carcinomas usually do not calcify and often infiltrate without producing a mass or altered density on the mammogram and therefore are often not visable on mammography. Lobular carcinoma is not "missed" but unfortunately not diagnosable by this method. Thus, a high percentage of ductal carcinomas can be detected by mammography while very few lobular carcinomas can. Miss rate (false negative), of course, varies a great deal with experience of the reader and the quality of the examination.

Approximately 40% of breast carcinomas will have associated microcalcifications. Unfortunately, many benign conditions also exhibit microcalcification. Because of this, the distinction between benign and malignant microcalcifications is not always possible. Hence, a significant proportion of

indeterminate groups of calcification may be discovered. In order to have an extremely low false negative rate, some radiologists will overcompensate and have a very high false positive rate resulting in a large number of benign biopsy rates by the surgeon who feels compelled to biopsy on the basis of a "suspicious" mammogram.

Several recent papers have dealt with the above problem. A surgeon who is asked to perform a biopsy or to consult on a mammographically identified nonpalpable lesion may be helped by a mammographic second opinion, possibly with additional high resolution films or special views. Also, a review of outside mammograms prior to scheduling a localization may be of value in reducing benign biopsies. Brenner et al. deals realistically with these problems.

It is still a matter of debate in the radiologic literature as to the ideal positive predictive value of the mammography. The spectrum ranges from 10-40%. Improved technique, magnification-compression views, and sonography have all decreased the benign biopsy rates the past couple of years. Magnification views are very valuable in assessment of microcalcifications and equivocal soft tissue abnormalities.

Screening Mammography vs. Diagnostic Mammography

Screening mammography is the testing of asymptomatic women from the general population to possibly detect a small or early cancer before it becomes large and/or spreads. In general, a definitive diagnosis is not given other than normal or abnormal. If the screening study is abnormal or suspicious, a full diagnostic study is then to follow. A diagnostic mammogram implies problem solving and often means considerable interaction between the patient, technologist, and the radiologist. The patient may be referred for an abnormal screening study or for a lump or other cause. The films must be developed and checked for technical quality. The radiologist then checks the study and may need additional magnification-compression views as the problem dictates. The problem should be resolved to the satisfaction of the radiologist before the patient leaves the department.

In practice, many facilities try to combine screening and problem solving at the same visit. Unlike a true screening program where films are processed later and read later, the patient may wait to be sure films are satisfactory before she leaves. Even excellent technologists may need to repeat a film because of unforeseen technical problems such as motion or positioning. If there is an obvious lesion or a hint of a problem, additional films can be obtained then, so that recall is averted. Patients do appreciate not having to return for additional mammograms.

Quality Control

Quality mammograms can be produced only with very strict attention to a large number of factors. Processing must be monitored very closely. Processor variability is recognized as one of the most important reasons for poor image quality and resultant higher radiation dose. Equipment must be monitored and adjusted frequently; radiation dose must be monitored and kept as low as possible. Technologist positioning, adequate compression, and attention to any clinical problem are all very important.

The American Cancer Society Check Up Guidelines include: breast physical exam for women aged 20-40 every 3 years; breast physical exam for women every year over age 40; breast self exam monthly. Mammography for women aged 35-39, one baseline study; for women aged 40-49, mammography every 1-2 years; for women aged 50 and over, mammography every year.

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MRI UPDATE

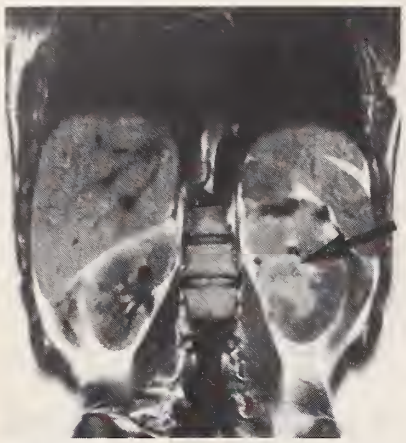

Figure 1

Figure 2

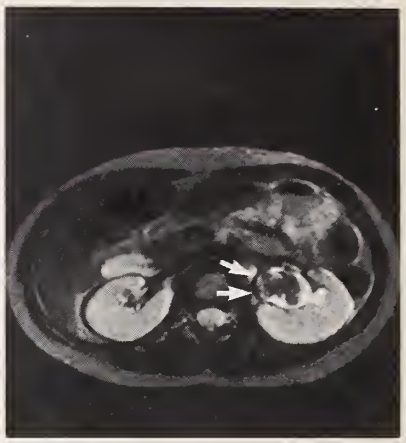

Figure 3

CLINICAL HISTORY: This is a 25-year-old female with complaints of left sided flank pain, nausea, and vomiting.

FINDINGS: Figure 1 represents a coronal T1-weighted image through the kidneys. A lobulated soft tissue mass conforming to the approximate shape of the left renal pelvis and the lower pole collecting system can be identified (large arrow). Signal intensity is intermediate and there is a central area of decreased signal intensity probably representing necrosis. Figure 2 is a sagittal image through the left kidney. In this projection, the soft tissue mass is comma shaped and can be identified extending from the left renal pelvis into the proximal left ureter (small arrows). Figure 3 is a T2-weighted image which exhibits increased signal intensity in the periphery of the mass and central decreased signal intensity. A curvilinear low signal structure lies medial to the mass and is felt to represent the left renal vein displaced by the mass. The vein appears to be patent as evidenced by the low signal intensity indicative of flowing blood (small arrows). No adenopathy is identified. There is no evidence of extension of the mass beyond the margins of the left renal pelvis or the proximal left ureter.

MR IMPRESSION: The location and shape of the soft tissue mass is typical for a transitional cell carcinoma.

MR NOTES: MR of the kidneys is a noninvasive procedure yielding both static and dynamic information about the pathologic process in question. In this case, the MR images defined the presence of the soft tissue mass in the left kidney, the confinement of the soft tissue mass to the left renal collecting system and the proximal left ureter, and the lack of invasion into the kidney and the adjacent pararenal soft tissue structures. In addition, the MR scan demonstrated that there is no evidence of thrombosis of the left renal vein nor is there evidence of tumor into the vein. MR imaging of the kidney is a noninvasive procedure allowing both anatomic identification of renal masses, staging of the extent of those renal masses, and determination of the presence or absence of renal vein involvement for surgical planning.

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Breast Cancer and Idiopathic Galactorrhea

Robert E. Rothenberg, M.D., Raymond D. LaRaja, M.D., Edith Pryce, M.D., Susan C. Mueller, M.D.

This study suggests that the incidence of breast cancer is approximately 100 times less among women who have experienced idiopathic galactorrhea.

For the past several decades, numerous investigations have looked into various factors that have or might have increased the risks of breast cancer. Some factors have been more or less generally acknowledged, such as a history of breast cancer among grandparents, parents, aunts, or siblings; a history of benign breast disorders, especially cystic disease; a prior cancer of the opposite breast; an early onset on menarche; a late age when the first child was born; a late onset of menopause; nulliparity; failure to breast-feed offspring; exposure to radiation; obesity; etc. Other factors that have been suspected but have not gained widespread acceptance include the prolonged use of oral contraceptive medications; long-term estrogen administration; alcohol abuse; the taking of various medications over long periods of time; etc.

Conversely, there have been studies that have pointed toward factors that might reduce the risk of developing breast cancer. Among these have been multiparity, the breast feeding of several infants, an absence of a familial history of breast cancer, an absence of cystic disease of the breasts, a diet low in animal fats and high in fiber, and avoidance of obesity.

The senior author's experience in more than 50 years of a surgical practice that included large numbers of patients with breast cancer has led to the conclusion that a milky nipple discharge that is unrelated to pregnancy and otherwise of unknown origin, or the past history of such discharge, is extremely rare in patients with this disease. Since an idiopathic milky discharge is experienced at some time or other during the life of many women, it was deemed interesting from an epidemiologic point of view to attempt to discover the incidence of breast cancer among that particular group.

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Idiopathic galactorrhea may be defined as a milk-like discharge from the nipple unrelated to pregnancy, parturition, prolonged lactation, amenorrhea or menstrual irregularities, pituitary tumors, thyroid or adrenal dysfunction, the ingestion of lactogenic drugs, persistently elevated serum prolactin levels, or any other known condition.

Nyirjesy[1] found idiopathic galactorrhea among 25 of 3,970 unselected gynecologic outpatients. This represents an incidence of 0.63 percent. Kleinberg, Noel, and Frantz[2] studied 235 patients with galactorrhea, of whom 222 were females and 13 were males. They stated that the cause of the galactorrhea could be ascertained in 196 of their cases, leaving 26, or 11.7 percent, of undetermined origin who therefore fell into the category of true idiopathic galactorrhea. On the other hand, Megido, Yodfat, and Kedar[3] reported that 30 to 40 percent of their patients with galactorrhea were of the "primary idiopathic" type.

To test the validity of the clinical observation that patients who have experienced galactorrhea are less likely than others to develop breast cancer, questionnaires were sent to 138 professors of general, oncologic, and breast surgery at medical schools throughout the country. The following questions were asked:

1) *Do you recall any patients with breast cancer who gave a history of galactorrhea or who had active galactorrhea at the time of surgery?*
2) *If so, how many cases do you recall?*
3) *Would you please give a rough estimate of the number of breast cancers you have seen during your career?*

When these questions to the respondents were submitted, it was realized that their recollections could not be precisely accurate. It was expected, however, that if a substantial number of their patients had experienced galactorrhea, they would at least recall some of them.

Some investigators believe that hyperprolactinemia, with or without galactorrhea, is a stimulant to the growth, and possibly to the formation, of breast malignancy.

In such an event, their statistics would reflect that recollection. The questionnaire purposely did not specify the type or origin of the galactorrhea that had been encountered, because it was our intention to inquire further into the matter from those respondents who answered in the affirmative.

A total of 72 responses were received, but two were excluded because their answers were incomplete. The respondents estimated that they had treated a total of 58,265 cancers of the breast during their careers. Eleven respondents recalled patients who either gave a history of galactorrhea or were experiencing it at the time of surgery. As a follow-up to the first questionnaire, the following inquiry was sent to them:

Did the breast cancer patient who had galactorrhea or who gave a history of galactorrhea, have:
a) A recent pregnancy;
b) Amenorrhea or menstrual irregularities;
c) Elevated prolactin levels;
d) Hyperthyroidism or adrenal dysfunction;
e) A pituitary tumor;
f) A history of ingestion of lactogenic drugs;
g) Any other related condition?

The replies to the second questionnaire showed that of the 11 surgeons who had encountered galactorrhea, only four of their patients could be categorized as having had idiopathic galactorrhea. The remainder were associated either with pregnancy, prolonged lactation, an endocrine disorder, or the taking of lactogenic medications.

Discussion

In reporting upon some 58,265 cases of breast cancer, our 70 respondents recalled only four patients, or 0.007% with a history or the presence of idiopathic galactorrhea at the time of their breast surgery. This statistic appears to be highly significant when one considers that idiopathic galactorrhea occurs in approximately 0.63% of all women at some time during their lives. Since there are approximately 82 million females over 25 years of age in the United States,[4] one might expect to find 516,600 instances of the condition. If this group contracted breast cancer in the same proportion as all women in this country, i.e. 10%,[5] one might expect to find 51,660 who had or have developed the disease. Instead, only four patients out of the 58,265 (0.007%), experienced breast cancer.

Although errors in reporting the incidence of idiopathic galactorrhea among the total of 58,265 cases of breast cancer seen by our respondents undoubtedly exist, the finding of only 0.007% with idiopathic galactorrhea or a history of the condition in this group compared to the incidence of 0.63% in the general female population is so great that it cannot be attributed solely to statistical error, faulty calculations, or poor history-taking. Even if history-taking omitted the

question as to the existence of galactorrhea, it can be assumed that it did include the question of the existence of nipple discharge. It is also a safe assumption that the characteristics of the discharge would have been described in a great many of the cases. If there had been a significant number with milky discharge, it would have been remembered by many more than four of the respondents. In this regard, Haagensen,[6] Kinne,[7] and Robbins,[8] who have treated many thousands of patients with breast cancer, responded that they had not recalled a history of or the presence of idiopathic galactorrhea in any of their patients.

Conclusion

The responses to our questionnaires suggest that the incidence of breast cancer is approximately 100 times less among women who have experienced idiopathic galactorrhea.

It should be noted that some investigators believe that hyperprolactinemia, with or without galactorrhea, is a stimulant to the growth, and possibly to the formation, of breast malignancy. However, *idiopathic* galactorrhea is usually not associated with increased serum prolactin levels.

The reasons underlying the low incidence of breast cancer in this group of women remain unclear.

Acknowledgement

We wish to thank the respondents who took time from their busy activities to answer the questionnaires.

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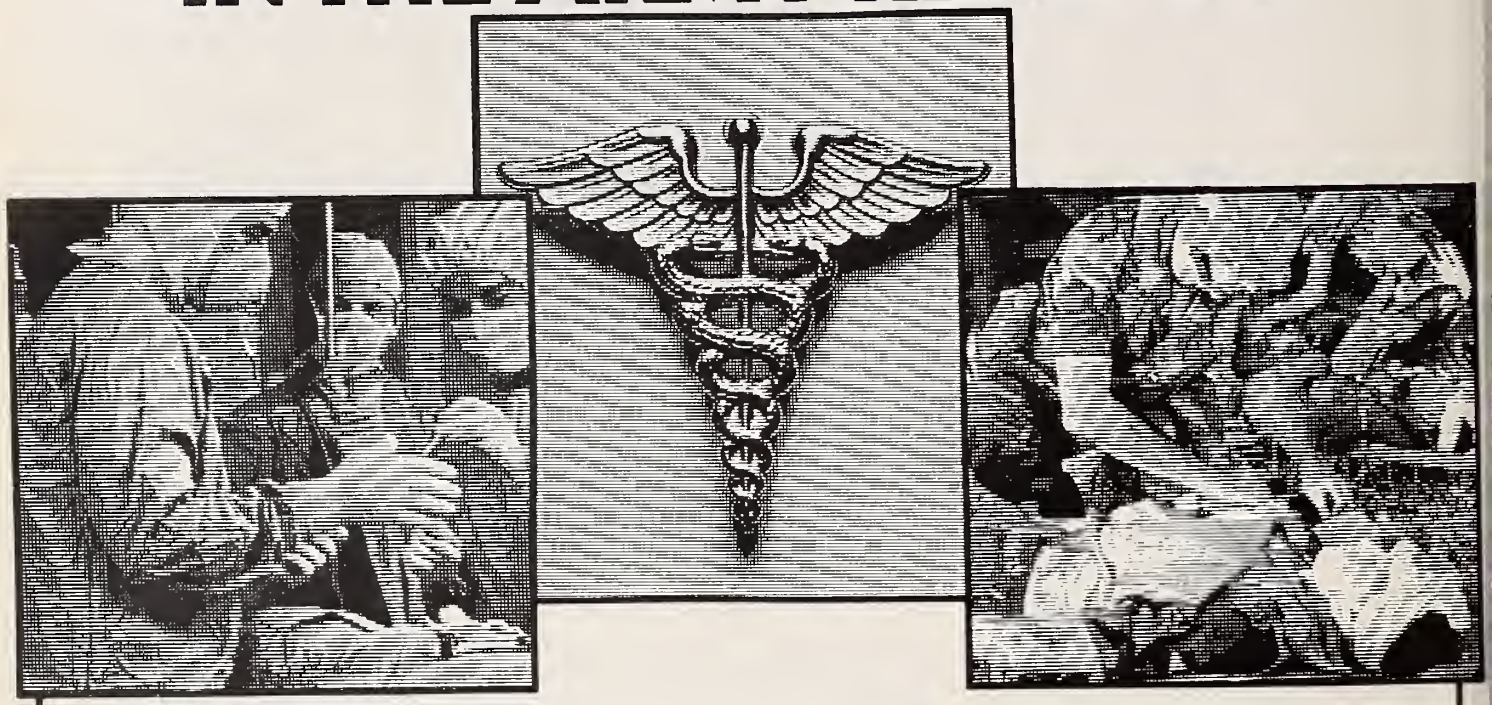

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ARMY RESERVE

Ninth District Medical Society Workshop Focuses on Illegal Drug Use

William A. Check, Ph.D.

"Few parents nowadays pay any regard to what their children say to them. The old-fashioned respect for the young is fast dying out."
— OSCAR WILDE

OSCAR WILDE'S REMARKS were typically ironic. But we would do well to take this one seriously, implied speakers at a workshop entitled "Illegal Drugs: What Are the Problems? Are There Solutions?" Organized by Rodney Smith, MD, President of the Ninth District Medical Society, and held in Gainesville, the workshop featured five speakers: an economist, a public health physician, a district attorney, an addictionologist, and a community youth leader. Although each person spoke from his or her own perspective, one theme was repeatedly sounded: The only effective way to deal with the drug scourge is prevention. Prevention begins with communicating with young people, and communicating includes listening.

This point was particularly underscored by the last speaker, Mr. Curtis Segars, a retired high school principal who heads the Clearinghouse, a Gainesville organization that works with youthful alcohol and drug offenders. Mr. Segars told the audience, "It is my opinion that we do not listen enough to young people." As a first step toward remedying this problem, Mr. Segars brought with him three high school seniors, who answered questions on adolescent drug use based on their first-hand observations.

The Financial Cost of Drug Abuse

The first speaker, Mr. Moncure Crowder, an executive vice president for First Atlanta, addressed the monetary aspects of illicit drug use in the United States. We know that drug use is a great economic burden on our society. "People who use illegal drugs add tremendously to the burden of health care," Mr. Crowder said. He included use of

As President of the Ninth District Medical Society, Dr. Rodney Smith, adult medicine practitioner and pathologist in Gainesville, was the initiator of and driving force behind the coordination of this workshop on illegal drug use. One stated goal was to focus on various solutions to this multifaceted problem.

Dr. Check is a freelance writer in Atlanta.

Mr. Moncure Crowder, Executive Vice President for First Atlanta, addressed the monetary aspects of illicit drug use in the United States. Mr. Crowder said that, further into the 1990s, he wouldn't be surprised to see a drug budget of $25 to $50 billion, with some of this money coming from a reduction in the defense budget. "With taxes already so high," he said, "it's going to be very difficult to come up with more money. We're going to have to devise better ways of using what we've got."

alcohol and tobacco products as costly, unhealthy behaviors. Already this is recognized in increased insurance premiums for people who smoke or drink. And he noted that the leading cause of death among young people is traffic accidents related to illegal drinking. These societal costs are difficult to quantitate, however.

An easier figure to arrive at is how much money the federal government spends to catch and punish offenders. In the 1990 budget, approximately $7.9 billion was earmarked for items relating to drugs, including federal, state, and local law enforcement; prisons; courts; prevention/education; and treatment. This represents an increase of $2.2 billion over the previous year.

Although this figure sounds high, Mr. Crowder noted that it is only two-thirds of one percent of the budget. "Obviously we rank the problem of drug abuse very far down our list of priorities," he said. For comparison, the defense budget is $300 billion annually. He said that, further into the 1990s, he wouldn't be surprised to see a drug budget of $25 to $50 billion, with some of this money coming from a reduction in the defense budget (When President Ronald Reagan took office in 1980, the defense budget was only $150 billion, Mr. Crowder pointed out.) The major obstacle to increased spending for drugs will be the "burdensome budget deficit," Mr. Crowder said. "With taxes already so high," he said, "it's going to be very difficult to come up with much more money. We're going to have to devise better ways of using what we've got."

In the 1990 U.S. budget, about $7.9 billion was earmarked for drug-related items. Although this figure sounds high, this is only two-thirds of one percent of the budget.

Prevention is an obvious candidate for increased emphasis. But, Mr. Crowder said, "We're not too good at preventing problems. We're better garbagemen — we're good at cleaning up afterwards." We will have to make "a tremendous shift in our lifestyles" toward prevention if we are to reduce the drug problem, he predicted.

Addressing another aspect of the drug problem, Mr. Crowder noted that, "Drugs are not the problem; drugs are a symptom of the problem." The root problem, in his view, is an increasingly distorted distribution of wealth in the U.S. For instance, measuring from 1973 to 1985 and projecting to 1995, the only group continuing to enjoy an increase in average income per household is households earning more than $60,000 per year. By 1995, the highest income bracket will have 13% of the population, but 50% of the nation's wealth. At the other end of the scale, there will also be an increase in the percentage of households earning less than $20,000 per year.

"As more people fall into the lower-income levels," Mr. Crowder concluded, "and as the gap between lower and upper income levels gets larger, as people continue to be bombarded by TV ads showing us what we need to live the good life, and as more people see that they are not going to be able to afford those things, there arises a class of people who lose confidence in our society. I have to believe that this promotes the use and sale of drugs," he concluded.

The Human Cost of Drug Abuse

Infant mortality, AIDS, syphilis, teen pregnancy, crack babies — all are an integral part of the world of Dee Stancil, MD, District Health Officer for the Georgia Department of Human Resources with responsibility for a semi-rural area in western Georgia. Formerly an anesthesiologist, Dr. Stancil is now certified in addiction medicine and works one day a week in a public substance abuse clinic in addition to her administrative duties. "Although we associate drug-related problems with urban areas," Dr. Stancil said, "they come to rural areas, too, just later." She enumerated the public health problems most frequently attendant on illicit drug use.

Infant mortality.

A major statewide initiative to lower the infant mortality rate has taken place in Georgia over the last few years, chiefly through in-

creased access to prenatal care. "We have done about as much as we can do from the public health aspect to combat infant mortality," Dr. Stancil said. Yet the infant mortality rate is still holding steady or increasing. This is largely due to low birthweight babies, those < 2 pounds, most of whom are born to drug-addicted mothers. In 1989, one of seven babies in the Neonatal Intensive Care Unit (NICU) in Atlanta's Grady Hospital was born to a mother with a drug addiction. In February, 1990, 30% of babies in the NICU at Grady tested positive for cocaine.

Physiologically, cocaine decreases blood flow to the fetus, leading to slow fetal growth and brain damage. These babies are typically mentally slow and require special services in school.

AIDS.

AIDS incidence is rising in both Atlanta and non-metropolitan counties. Dr. Stancil explained that a dramatic rise in AIDS in counties in southeast Georgia is due to drugs being brought in through Jacksonville, Florida (since Miami is under stricter surveillance), and then coming up the I-95 corridor. AIDS cases among homosexuals increased 100% in Georgia last year (112% in the nation), but cases of AIDS among intravenous drug abusers in Georgia increased 292% (231% in the country as a whole). Drug abuse is the "fastest growing method of transmission" of AIDS today, Dr. Stancil noted.

Syphilis.

Beginning in 1987, the number of cases of syphilis has dramatically increased, according to Dr. Stancil, especially among blacks. She attributed this increase to "sex for drugs," especially among lower-income women, and especially for cocaine.

Due to the rise in syphilis, congenital syphilis is reappearing. "I had never heard of a contemporary case of congenital syphilis," Dr. Stancil said. But there were three cases of congenital syphilis among babies born in Carrollton in 1989, all to cocaine-addicted mothers.

She pointed out two problems aggravating the current drug epidemic: the intensely addictive nature of cocaine, especially crack, and the difficulty of treating addicts in the public sector.

Because of its addictive potential, use of cocaine has become widespread. Admissions to treatment units in Georgia, both public and private, for crack/cocaine addiction rose from 5,000 in 1984 to 10,000 in 1987 to 20,000 in 1989. To highlight the addictive power of crack, Dr. Stancil cited the words of a young woman whom she counseled about the danger of shared needles and HIV infection: "The high is so great, and I need it so bad, that I don't care."

Addiction is so prevalent in low income areas because crack is such a cheap high, with a hit selling for $5 to $10. At this low price, even teenagers become entrapped. In a typical crack house, there are mattresses on the floor and teenage girls trade sex for crack. This leads to teen pregnancy, with low birthweight babies. In addition, it greatly increases syphilis and gonorrhea transmission. Even worse, Dr. Stancil said, "You can't trace sexual contacts because these males can't remember all the people with whom they have had sex."

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Because this drug epidemic is occurring disproportionately among poor people and adolescents, who do not have private health insurance, the burden of treating cocaine addiction is falling largely on the public sector. Unfortunately, the family situation is often part of the problem among these clients, with other members of the family using drugs as well. And many lower-income addicts live in projects, where drug dealers are powerful. A recovering drug addict "can't make it without a strong support system," Dr. Stancil pointed out, but many teenage cocaine addicts live in dysfunctional families.

Dee Stancil, M.D., District Health Officer for the Georgia Department of Human Resources, enumerated the public health problems most frequently attendant with illegal drug use, including infant mortality, AIDS, and syphilis. According to Dr. Stancil, the high infant mortality rate is largely due to low birthweight babies, those < 2 pounds, most of whom are born to drug-addicted mothers. In February, 1990, for example, 30% of the babies in the NICU at Grady Memorial Hospital in Atlanta tested positive for cocaine.

In addition, Dr. Stancil related, in the current drug epidemic there is a tremendous prevalence of young polydrug abusers. It is more difficult to deal with this type of addict. The current addiction treatment model was set up for middle-aged alcoholics. It doesn't deal with younger people who are abusing several hard drugs.

District Attorney Andy Fuller, whose jurisdiction covers Hall, Dawson, White, and Lumpkin counties, said that 40% of his caseload is directly related to drug infractions. "Cooperation across jurisdictional and geographic lines has not always been the rule," Mr. Fuller admitted ruefully. To alleviate this obstacle, a recent federal initiative has promoted multi-jurisdictional task forces. Law enforcement officers from several agencies are assigned to a single task force which is responsible for making drug charges against individuals.

What Can Law Enforcement Agencies Accomplish?

"Forty percent of my caseload is directly related to drug infractions," said the next speaker, District Attorney Andy Fuller, whose jurisdiction covers Hall, Dawson, White, and Lumpklin counties. Mr. Fuller characterized himself as "the conservative wing of these presentations," informing the audience that he intended to stick to the law-enforcement aspects of drug use.

Nonetheless, Mr. Fuller, too, presented the use of illegal drugs as a societal problem. In his opinion, "The largest problem I see is that there are very few groups of citizens attempting to address the ultimate solution." This is because the price of combating drug use is very high and because the problem is so complex that there is no single, easy answer. "We district attorneys consider it the toughest problem that we have ever faced," Mr. Fuller said. He quoted former federal prosecutor Robert Barr as saying drug abuse was "the only problem I have ever seen that could destroy our society."

Nor does Mr. Fuller believe that prosecution is a panacea. "I'm not a proponent of the theory that law enforcement can solve this problem," he said. He believes that it will take several approaches combined — education for prevention, treatment, rehabilitation, and law enforcement — if we are to have a chance of ending the ravages of drug abuse. "Education has to take the leading role in solving this problem," Mr. Fuller emphasized, "especially at the elementary school level." And requiring treatment, rather than simply jail, is another step that will eventually have to be taken.

Another unpleasant truth presented by Mr. Fuller is that drug use continues only because the network of importation, distribution, and sales includes many "major players." One member of respectable society who can assist the drug trade is the county sheriff. In Georgia, a number of sheriffs have been removed from office for involvement in drugs, Mr. Fuller said. For instance, some have allowed planes loaded with drugs to land in their counties.

Law-abiding people also become criminals through the temptations of money-laundering. Street sellers and their distributors don't have the resources to handle the money that is moved in the drug trade. Georgia state attorney general Mike Bowers has estimated that profits from drug dealing in Georgia alone are $10 billion annually. Laundering this amount of money requires people inside financial institutions. "We have bank people, industry people, who are involved in the financial end of the drug business," said Mr. Fuller. "It's extremely difficult to get at those people."

Gathering evidence to convict such "major players" requires extensive time and money and sophisticated investigatory means, such as searching bank records of legitimate businesses for sums of money with no apparent source. A federal statute, the Asset Forfeiture Bill, allows seizure of a drug offender's property if it is related to a drug sale. A state bill mirroring the federal statute did not pass the Georgia state legislature last year. Perhaps, Mr. Fuller speculated, it was because approximately one-third of the legislators in the Georgia house are defense attorneys.

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The newest weapon in the fight against higher-level operators, put into effect in late March, is the federal power to subpoena fee records of attorneys who defend drug figures. What investigators look for is large cash payments, which could represent drug profits.

At the street level, the typical procedure is for a law officer to make contacts with drug-dealing persons, then set up a buy. Money seized from offenders is used to buy the illegal substances.

However, even this basic approach has traditionally been hampered by "turf battles" among law enforcement agencies. "Cooperation across jurisdictional and geographic lines has not always been the rule," Mr. Fuller admitted ruefully. To alleviate this obstacle, a

recent federal initiative has promoted multi-jurisdictional task forces. Law enforcement officers from several agencies are assigned to a single task force which is responsible for making drug charges against individuals. Officers on the task force can develop expertise in how to make a charge stick and how to trace back from street dealers to higher level distributors.

"This is probably the only law-enforcement approach that has a chance to be successful," Mr. Fuller concluded.

Drug Addiction: "Treatable and Preventable"

For some persons who have the motivation to attempt to cease drug use, residential treatment programs are a favored option. Karl Gallegos, MD, is director of the Inpatient Adolescent Unit at one such institution, the Talbott Recovery Center in College Park. He described the medical aspects of drug addiction, the detrimental consequences of addiction, and the currently favored biomedical model.

Dr. Gallegos began by pointing out that we don't even know the true number of drug users. One source of statistics is the annual high school seniors survey. But it has been demonstrated that students lie; and the sample is skewed by not including high school dropouts, who are more likely to be drug users. A more reliable source of information is the National Institute of Drug Abuse's Drug Abuse Warning Network (DAWN). In this program, cocaine or heroin overdoses treated in emergency rooms and deaths attributed to cocaine or heroin by medical examiners are tabulated. From 1984-1988, DAWN found a fourfold increase in drug-related deaths and a threefold increase in overdoses. These "hard data" imply that drug abuse is increasing, Dr. Gallegos said.

He showed the mortality caused by substance abuse to set the scope of the problem. Each year, more than half a million deaths are caused by diseases attributable to the use of tobacco (100,000 deaths), alcohol (350,000), and other drugs (75,000). This *annual* total is greater than all American deaths in wars during the last century.

Dr. Gallegos summed up these figures in a startling statistic: "If you could eliminate all deaths attributable to tobacco, alcohol, and drug abuse, you would extend life expectancy by about 10 years."

Preventing and treating addiction requires an understanding of how addiction develops. Dr. Gallegos described the current biochemical model. In the first step, people are culturally induced to abuse drugs. For most users there is a genetic and biochemical "wall" that allows an individual to hold drug use under control. But for some, the wall acts more as a gate, promoting the third step, the disease of addiction, or compulsive drug use. In this last phase, Dr. Gallegos summarized, "You become powerless over the drug."

Some facts are known about the biochemistry of the addictive process. It takes place largely in the hypothalamus, where appetites for sex, food, and thirst are altered. Neurotransmitters in the hypothalamus are depleted, and receptors are altered. Pathways to the cortex have been demonstrated that inhibit drug reinforcement and lower the risk of addiction. But research shows that cocaine in particular ablates this "Nancy Reagan part of your brain," Dr. Gallegos said, explaining its tremendous addictive potential.

For different substances, the final addictive phase takes different lengths of time. Dr. Doug Talbott has treated more than 2,000 physicians. Dr. Gallegos searched the records to see how many years of use it took for these persons to become "hopelessly addicted." If alcohol was the patient's drug of choice, it took 22 years; for Demerol, it was 8 years; but cocaine took only an average of 1 year of use to lead to chemical dependence.

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Karl Gallegos, M.D., Director of the Inpatient Adolescent Unit at the Talbott Recovery Center in College Park, described the medical aspects of drug addiction. For most users, there is a genetic and biochemical "wall" that allows a person to hold drug use under control. But for some, the wall acts more as a gate, promoting the disease of addiction, or compulsive drug use. Dr. Gallegos emphasized the need for prevention by noting the failure of interdiction strategies.

Although these facts paint a grim picture, "In my opinion drug addiction is both treatable and preventable," Dr. Gallegos asserted. He presented data from a study conducted in New Zealand, in which all hospitalized persons were followed until death, including those in the hospital for drug or alcohol abuse. The investigators calculated a mathematical measure of the probability of recovery related to the number of hospitalizations. There was a reasonable chance of recovery after the first hospitalization. The cumulative recovery curve decreased gradually after each hospitalization. That is, the more times a person went through treatment, the less added chance he or she had of recovering. Thus, addicts identified and treated early have a better chance of kicking their habit, but this chance decreases rapidly.

Dr. Gallegos further emphasized the need for prevention by noting the failure of interdiction strategies. In 1989, more than 100 tons of cocaine were seized coming into the U.S., yet the street price of cocaine decreased. The only way to fight this problem is at the demand end. "We're living in a substance-abusing culture," Dr. Gallegos noted, "where the demand for drugs is intense."

Based on his experience treating adolescents, Dr. Gallegos believes that drug prevention education needs to start in the earliest years. "Most of the kids I treat were already using when they're 8 or 9 years old," he said. As a result, he gives talks to very young schoolchildren, using the reward methods appropriate to this age group.

Listening and Loving

The last speaker on the program, Curtis Segars, spoke from a background of 30 years as a teacher and high school principal. He coordinates the Clearinghouse, a Gainesville group set up to be a permanent, full-time liaison body between adults and young people, particularly young substance abuse offenders.

After the statistical and technical presentations of the previous speakers, Mr. Segars struck a very personal note. He gave three keys towards helping young people to avoid drug use or to stop it after they start. First, listen to young people. Second, be consistent in your treatment of them. Third, when a young person makes a mistake, tell them you love them. "I believe that treating young people much better, with love and consideration, will help combat the drug problem," Mr. Segars said.

Among those in the Gainesville community attending the workshop were (L to R) Dr. Ted Robinson, an industrial medicine specialist at Chicopee (a branch of Johnson & Johnson); Mr. Bob Bennett from the Employee Assistance Program at Chicopee; and Dr. Charles Brown, Director of the Alcohol and Drug Unit at Laurelwood.

In addition, rapid response to a youngster's distress is imperative. "Someone needs to see a youngster at the exact time that he or she cries out for help," Mr. Segars stressed. That is one function of the Clearinghouse.

He also called for change in adult attitudes. Based on his experience speaking at middle and high schools in Hall County during the past year, he finds that there is more finger-pointing than constructive action. "Most of us do not believe that *we* have a problem," Mr. Segars said. "Most of us believe that *they* have a problem. Until we can change that attitude, we will all continue to have a problem."

To show that he was serious about listening to young people, for the second half of his presentation Mr. Segars brought in three high school seniors to answer questions from the audience. Some of the questions and the three students' answers follow:

Q. *Have you been taught to resist peer pressure on drugs?*
A. Resisting has to come from the individual. You need reinforcement from parents. The ability to resist peer pressure on drugs comes mostly from parents and early upbringing.

Q. *How many students at your school have used drugs?*
A. Estimates at the three schools varied from about 30% to 60%.

Q. *How many students at your school regularly use alcohol?*
A. All three students said about 90%, especially on weekends. One said that, with almost all parents using alcohol, it was not surprising that most kids use it, too.

At this meeting, these three young people had the last word. Perhaps that is fitting with a problem that poses such a threat to every one of our children. ■

Needed: A Georgia Institute of Agricultural Medicine

Arthur M. Smith, M.D.

THE RAPIDLY GROWING efficiency of American agriculture is the basic foundation upon which rests both our economic and military might. Without question, we all recognize that steel, oil, aluminum, coal, rubber and many other factors have been important to our economic stability. In referring to such traditional industrially related resources, however, the late Senator Richard B. Russell stated, "But none of them — not even all of them put together — are as basic as food and clothing." This nation's identity as a world economic power, in view of our shrinking position in "smokestack" and high technology industries, increasingly depends upon healthy farms and agribusiness.

Agriculture is also of special importance to Georgia and is one of its largest industries. It has been estimated that more than half of all Georgians are employed in jobs relating in some way to agriculture — farming, agricultural equipment manufacturing, food processing, farm supply, transportation, and export. The farming and agricultural industrial population within this group is of special importance. This includes those people involved with the production of raw agricultural products (food and fiber), including farm owners, farm operators, family farm members, and hired workers. It also encompasses those people involved with the processing and transport of raw agricultural products, such as livestock truckers, packing plant employees, and dairy processing plant employees. Those involved with farm support industries, such as veterinarians, grain elevator workers, farm chemical manufacturers, and pesticide applicators, are also included.

Our Georgia farm and agricultural population (which is estimated to constitute half the state's population) labors daily in an environment characterized by multiple physical, chemical, and biological hazards.

Often forgotten is the fact that our Georgia farm and agricultural population labors daily in an environment characterized by multiple physical, chemical, and biological hazards. Sadly, this acknowledgement is abetted by the fact that many of these same people live and work in 77 counties in Georgia which are currently designated, in whole or in part, as health manpower shortage areas by the Department of Health and Human Services.[1] These issues, unfortunately, provide stark contrast to the reality of our dependence upon these very same people in agriculture, who in the final analysis, are the critical underpinnings of our national economic strength in the world's markets.

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The gravity of the risk threat is exemplified by a study performed to analyze tractor-related accidents in Georgia. Between 1971 and 1982, a total of 202 tractor-related deaths occurred. Accidents occurred in 103 of the 159 counties in Georgia, and all but 18 occurred on farms. Fatal injuries occurred for 153 persons when the tractors overturned, 28 were "run over," and 6 drowned when their tractors fell into a stream or lake. Eighty-three percent of fatalities were attributed to crushing chest injury, and other causes were noted to be external hemorrhage, strangulation, asphyxia, and drowning.[2]

Deaths obviously represent the most extreme consequence of tractor accidents, and a much greater number of serious and disabling injuries probably occur. This is perhaps best exemplified by an article published in the *Augusta Chronicle* several years ago entitled, "Victim of Farm Accident in Fair Condition." The article described the plight of a 9-year-old youngster who fell into a compost spreading machine pulled by a tractor. Falling into the power-take-off shaft of the machine, one of his arms was severed, and the other mangled and later amputated. In addition, both legs were broken.

The National Safety Council noted several years ago that there were 1900 deaths and 200,000 disabling injuries annually from agricultural work accidents in the United States. In 1984, the Centers for Disease Control indicated that the 52 occupational traumatic deaths per 100,000 workers in American agriculture per year was second only to the mining and quarrying industry, which annually experienced 55 deaths per 100,000 workers.[3]

To further underline the hazardous nature of the agricultural environment in general, an article appearing in *Lancet* in 1987 described the plight of rice farmers in the Philippines. It noted that since rice farmers started growing Western rice species over a decade ago, and using the pesticides needed to protect these species, their mortality rate from causes other than trauma had increased 27%. Many of the liquid pesticide agents in common use have been previously classified by the World Health Organization as hazardous. The pesticides are often applied several times per crop from a backpack sprayer, and no protective clothing is used or even available locally. The authors suggested a causal link between pesticide use and the poisonings, and stressed that the figure of 10,000 deaths worldwide from accidental and occupational poisoning must be a substantial underestimate. Since economically active men, often the heads of households, are the victims and are most at risk of poisoning, the social impact is probably greater than such numbers indicate.[4]

Could pesticides, metals, and nitrates have an effect upon fertility and other reproductive functions? Could these lead to deficiencies in various metabolic or endocrinologic factors?

A color photograph of Welsh sheep pens in the September 9, 1988, issue of *AMA News*, with its associated caption, infers another facet of the hazardous agricultural environment. Under the title, "A thriving market town," it notes that in the south Wales town of Abergavenny, animal-related illnesses are common. The local medical clinic cautions pregnant women to avoid sheep and sheepherders lest they contact Chlamydia.

The Problem

Until now, the farmer has been fortunate that his exposures to many hazards in the agricultural environment have been mixed and highly intermittent. Specialization is now occurring in agriculture, however, and the size of farming operations is increasing. Fewer people will undoubtedly be exposed to these hazards for longer intervals, inevitably resulting in a greater incidence of health-related difficulties.

The agricultural worker is generally less inclined, and in terms of the technical aspects is least able to understand, basic industrial hygiene objectives and procedures. In addition, farmers have traditionally resisted any activity which ultimately might result in restrictions or controls over their activities. Consequently, medical aspects of hygiene control do not exist on the farm. There are no pre-placement and periodic physical examinations of farm workers. There is no medical monitoring, no rotation of workers or prophylactic measures. (Only sheer naivete would permit serious consideration of blood cholinesterase levels for migrant farm workers.) Personal protective equipment may not be available or may be inappropriate for agricultural use. Personal hygiene undoubtedly varies in applicability, being affected by the facilities available and the inclinations of workers to use them.

An examination of the chemical, physical, and biological hazards faced by the agricultural worker and the various problems associated with these hazards raises some pointed issues that should be addressed by the medical profession.

Chemical Hazards

Chemical Hazards Brought to the Farm

The farmer is the end user of large amounts of a wide variety of chemicals. Prominent examples of these agents are insecticides, such as or-

ganophosphates, carbamates, and chlorinated hydrocarbons. Other exposures include herbicides, rodenticides, defoliants, soil sterilizers, growth regulators, fumigants, nematocides, fungicides, acids, alkalis, solvents, fuels, lubricants, veterinary pharmaceuticals, feed additives, fertilizers, soil modifiers, and others. Nevertheless, there is a dearth of information on chemical exposures of people associated with agricultural pursuits.

The primary hazard of exposure to many of these agents is the development of acute toxic reactions as a result of dermal contact with or inhalation of a relatively large dose. The effects of acute intoxication are usually manifested within minutes or hours after contact.

The effects of low-level or prolonged exposures, however, particularly the carcinogenic potential, is a far different matter. This is especially true for pesticides, herbicides, fungicides, metals, toxic gases (such as H2S and NH3), as well as high concentrations of nitrates in water supplies. Assessing the cancer risk of these agents can be difficult, since no adverse effect may be apparent until long after the cancer causing exposure has occurred. Thus, by the time the medical and scientific community is aware, or has been alerted to the potential risk of exposure, a sizable number of persons could have been unwittingly exposed and become cancer victims.

An even more subtle yet virtually unknown aspect of toxicity may pertain to subclinical or inapparent toxicities of these agents. Is there any possibility of immune suppression, manifested perhaps through vaccine failure, from exposure to pesticides, herbicides, fungicides, metals, mycotoxins, and other chemicals? Could pesticides, metals, and nitrates have an effect upon fertility and other reproductive functions? Could these lead to deficiencies in various metabolic processes, such as synthesis of hemoglobin, or various endocrinologic factors? Could deficiencies in drug/chemical metabolic competence lead to blockade of hepatic detoxification functions, or perhaps induce aberrant hepatic processes that, for example, activate carcinogenic metabolites from mycotoxins? Could such exposures lead to subtle anemias or clotting disorders, etc., as well?

The agricultural worker cannot be expected to have the degree of toxicologic expertise to insure adequate protection against chemical hazards. In the area of labeling and usage instructions, for example, engineers and industrial hygienists have basically failed the agricultural worker.

Interest in the long-term mutagenic and carcinogenic effects of such chemical exposures upon farmers and other agricultural workers is certainly appropriate. (For example, midwestern farmers have a higher than normal chance of contracting leukemias and lymphomas. It has been intimated that the unusual incidence of leukemias in major corn producing states suggests a possible link to use of modern pesticides.)[5-8] This largely independent group of workers has had virtually no protection under the Occupational Safety and Health Codes, and yet has had large exposures to chemicals since the 1960s — an era of high volume agricultural use of chemical and biological substances. Unfortunately, the agricultural worker cannot be expected to have the degree of toxicological expertise, the engineering know-how, and the time and resources to insure adequate protection against chemical hazards. In the area of labeling and usage instructions, for example, engineers and industrial hygienists have basically failed the agricultural worker.

Chemical Hazards Produced on the Farm

Inhalation of dusts, smokes, spores, vapors, gases, and aerosols of spray procedures are fundamental hazards of the farming occupation. Of growing interest are the hazards to agricultural personnel of gases present in large confinement feeding operations such as in swine, cattle, and poultry producing operations (Georgia ranks first nationally in poultry product production, and second nationally in broiler and egg production). Exposure to dangerous levels of carbon monoxide, ammonia, and hydrogen sulfide have been actually measured in swine feeding operations.

Documented exposure of farm workers to oxides of nitrogen have been associated with recently filled silos. If the forage put into the silo has been raised under drought conditions and high nitrogen fertilization, the problem seems to be more severe. Sometimes, a yellow gas can be seen above the surface of the silage within a day or two after filling, and may persist for several weeks. It may cascade down the chute and kill small animals such as fowl, at the bottom of the silo. A brief exposure, such as that associated with entering the silo to recover a tool, may be fatal.

Further silo hazards emanate from the fact that more and more silos are being sealed after forage addition, with resulting different

ventilation requirements. Under these anaerobic fermentation conditions, carbon dioxide may build up and oxygen is usually depleted. Self contained respiratory protective equipment is often not available, and entry into the silo is often fatal. There are several such deaths annually.

The nascent interest in "agricultural medicine" in Georgia can best be developed by supporting epidemiologic activities that define the nature of the problems. An epidemiologic unit within the Institute should obviously have a high priority.

In addition, exposure to exhaust gases from internal combustion engines — diesel, gasoline or petroleum gas — is common. These result from operations where these engines, large or small, are operated in confined spaces.

Physical Hazards on the Farm

Each year in the United States, tractor accidents alone account for an estimated 500-600 fatalities. Overturns and falls from tractors are all too frequent. Other tractor connected injuries and damages involve: collisions with motor vehicles or roadside objects; slipping and falling while mounting and dismounting; running over bystanders; striking overhead hazards; being struck by flying objects, broken parts, or hydraulic fluid; being crushed by a poorly supported tractor during repair work; and being burned by fires that erupt during refueling or as a result of a collision or upset.

In addition to the striking accidental farm death statistics generated yearly by the National Safety Council, thousands more have suffered disabling injuries. Millions of dollars annually are lost due to property damage, medical bills, time off from work, reduced productivity, and added insurance costs. In recent years, medical symposia based upon physician experience with problems of the agricultural setting have included programs on the mechanisms and management of auger, cotton picker, and irrigator injuries. Corn picker hand injuries and hydraulic injection injuries as well as major injuries from power take-off shafts have also been discussed. These and other assorted injuries continue to raise questions concerning the reality of safe machinery operation in the agricultural setting.

Extremes of heat and associated exertional injury, manifested in terms of heat stroke, and associated cardiovascular, metabolic and fluid/electrolyte disorders, also impact upon the farm worker. The indolent cutaneous carcinogenicity of solar exposure, as well as the potential for eye damage, are further risks associated with protracted exposure to sun radiation.

Traumatic corneal disruptions due to flying objects are seen with some regularity, as well as anhydrous ammonia eye burns due to unsafe handling of such chemicals. The effects of vibration, accrued through long hours riding on unsprung vehicles over non-smooth terrain, can translate into vertebral disease and prostatitis. Noise, a related environmental hazard, emanates from unmufflered internal combustion engines, power transfer devices (gears, chains, belts, sprockets, tumbling rods), as well as fans and vibrating metal paddles. Protracted exposures to these machine noises easily exceeds generally considered safe limits and must inevitably facilitate hearing deterioration.

Documented exposure of farm workers to oxides of nitrogen have been associated with recently filled silos.

Biological Hazards on the Farm

Envenomization injuries and deaths of agricultural workers have been a worldwide problem. With regularity, agricultural workers encounter bumble bees, wasps, yellow jackets, hornets, fire ants, and snakes. Internal and external parasites are similar threats. Various human parasites may find reservoirs in animals and poultry, and eventually reinfect a farm worker. Similarly, animal and poultry parasites may use humans as intermediate or atypical hosts.

Historically, the transmission of tuberculosis from cattle to humans is well known. Brucellosis, histoplasmosis, anthrax, toxoplasmosis, and leptospirosis are also some of the well known sequelae of exposure to the farm environment. It is also known that various human diseases — bacterial, fungal, and viral — may be perpetuated in animal hosts and subsequently reinfect farm workers through exposure to dirt, sewage, excreta, and silage contact. Through similar routes, various animal diseases known as zoonoses, common to beef cattle, poultry, sheep, and swine are also transmissable to man. The World Health Organization has listed nearly 170 diseases common to animals and man, and probably one third of them are capable of affecting agricultural workers.

Further questions relate to whether immune competence of farm workers, weakened through the synergistic effects of chronic exposures to farm chemicals and acquired nutritional deficiencies such as selenium (reflecting a widespread soil deficiency in Georgia leading to similar deficiencies in plants and animals, and thence in human foods) increases their susceptibility to acquiring animal transmitted diseases.

Realities

Farming remains a production oriented occupation. Not only has the U. S. Department of Agriculture been a motivating force in the promotion and development of agriculture, but perusal of most farm magazines will similarly reflect this orientation "within the trade." Federal farm policies have indirectly generated serious new health problems, however, by encouraging the development of an industrial-type agriculture. Nevertheless, in the final analysis we must not lose sight of the fact that the health of the farmer and agricultural worker has a direct relationship to productivity. Clearly, farming's image as clean, healthy work, is now a myth. Although the short-term risks of this occupation are clearly evident, the long-range risks of modern farming are not well understood.

What Can We Do?

As the next century approaches, Georgia will emerge as the agricultural and natural resource leader of the Sun Belt economy. The University System of Georgia will undoubtedly become the dominant force in this development. It will provide the graduates in higher education, the new knowledge through research, and the educational programs to expand Georgia's significant contributions to the Southeast, the nation, and the world. The need for graduates with advanced training in agriculture will be filled through graduate training and expanded research programs. As this is accomplished, graduate and research programs with national and international recognition will evolve. Concurrently, the need for an academic entity specifically devoted to examination and study of the health needs of individuals working in the agricultural environment, namely a *Georgia Institute of Agricultural Medicine*, should also warrant serious consideration.

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A Georgia Institute of Agricultural Medicine: Its Charge

It is often acknowledged that effective public health programs have a strong epidemiologic component. Unfortunately, little prior epidemiologic and related medical research has been done for detection and evaluation of the industrial hygiene problems of the Georgia farm and agricultural population, who daily labor in an environment characterized by multiple physical, chemical, and biological hazards. Epidemiologic work can take many forms, such as field studies, outbreak investigations, analysis of morbidity reports, etc., but they all encompass the activities of data collection in the field, central analysis of the data, and the distribution of the results to those who have a need to know.

Can competent authorities in Georgia say what the specific health problems are in various agriculturally related occupations? If they can more specifically define the "health threat," then inevitably political, financial, and administrative support will "fall into line" in terms of research grants, industrial support, etc. The nascent interest in "agricultural medicine" in Georgia can best be developed by supporting epidemiologic activities that define the nature of the problems. An epidemiologic unit within the Institute should obviously have a high priority.

Furthermore, many rural areas in Georgia lack physicians. Unfortunately, methods of attracting newly trained physicians into rural practices and keeping them there are not well developed. Many students studying medicine in Georgia are drawn from rural areas. Similarly, various students initially express an interest in returning to rural areas. At some further juncture during the educational process, however, many of these same students choose specialty fields and decide to remain in urban centers. Comments often heard from medical students are that medical school does not prepare them for the diversity of health problems faced by rural practitioners.

Most medical school curricula have, at best, cursory coverage of problems, such as pesticide poisoning, zoonotic diseases, or respiratory problems of agricultural workers. Early in their careers, students must be introduced to a holistic view of rural patients, working in an environment laden with chemicals, machinery and infectious diseases that may threaten their health. Developing interest in such specific rural health problems requires curriculum input from a high level research and teaching center with credibility and visibility.

Drawing upon the resources of the agricultural, engineering, medical, educational, and sociologic expertise within this State, a re-

search and educational vehicle such as the proposed Georgia Institute of Agricultural Medicine would serve as a focal point for both legitimately defining the nature of these distinctly agricultural health problems and for attempts at investigating potential solutions. It would also serve as a point for training potential rural practitioners to identify the rural communities that sorely need preventive medicine programs and teach them where and how the physician must initiate such programs, if anyone is going to.

A whole new generation of health hazards is emerging amidst the revolution in agricultural technology. A *Georgia Institute of Agricultural Medicine*, acting as a vehicle for both research and education, would act as the "transmission antenna" for advocating and promoting interest in the agricultural worker and the environment in which he and his family both labor and reside. For a state such as ours, with extensive human involvement and heavy economic investment in the sphere of agricultural production, the institutionalization of this concept is worthy of serious consideration.

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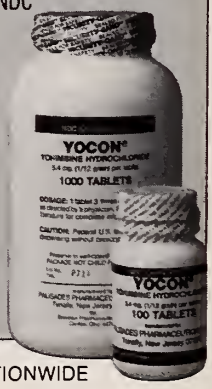

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The Neonatal ECMO Experience at MCG: The First Fifty Patients

William P. Kanto, Jr., M.D., R. Frederick Boedy, M.D., Charles G. Howell, M.D.

Prior to ECMO, all patients received a cranial ultrasound to exclude CNS anomalies and intracranial hemorrhage plus an echocardiogram to identify congenital cardiac disease and evaluate cardiac function.

Introduction

EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO) was first successfully used in the treatment of moribund infants with respiratory failure unresponsive to conventional therapy in 1976.[1] Encouraging results led to the development of criteria in the early 1980s to identify infants with predictably high mortalities despite conventional therapy for whom ECMO offered a potential rescue.[2]

Initial reports of ECMO "rescues" described an unanticipated rate of recovery.[2] A subsequent controlled trial demonstrated improved survival in ECMO patients versus those treated conventionally.[3] Although the statistical analysis of this paper has been criticized, the results were strikingly supportive of the use of ECMO. A more recent, traditionally designed study also favored ECMO use.[4]

Significant complications may occur with ECMO including hemorrhage, hypertension, stroke, and seizures.[5-7] These complications, along with unknown effects of right common carotid artery sacrifice during cannulation, made the neonatal community hesitant to use ECMO except in life-saving circumstances.

The Medical College of Georgia ECMO Program began in March, 1985. With the above concerns, we limited ECMO use to infants believed at great risk of dying of respiratory failure. Here we report the results of our first 50 patients.

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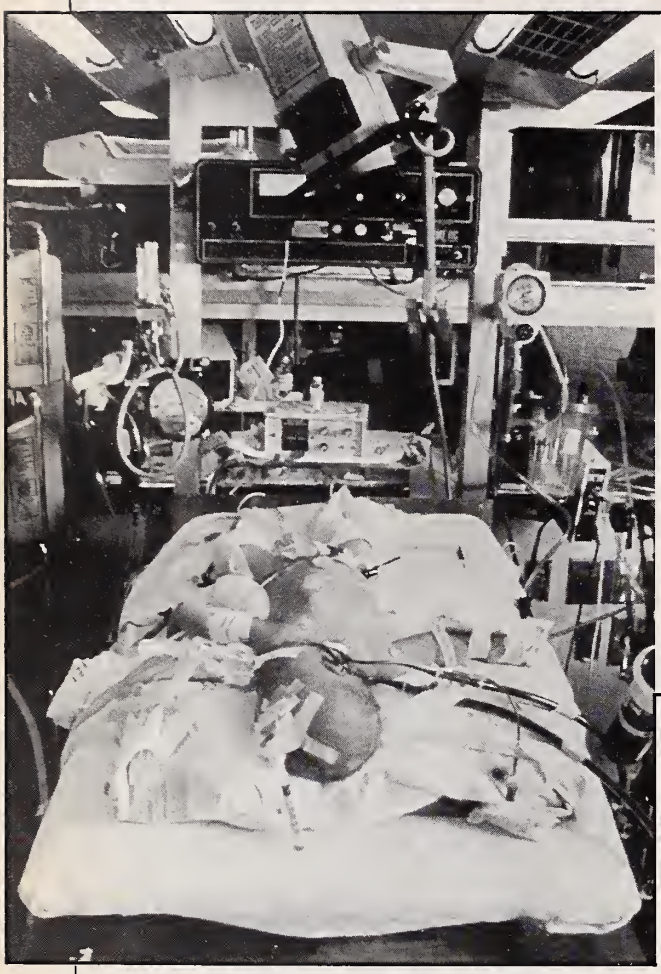
Materials and Methods

Medical records and the data base generated during ECMO therapy for our first 50 ECMO patients were reviewed. Demographic information including gender, gestational age, birthweight, site of birth, age placed on ECMO, and ECMO duration was abstracted. Diagnosis, criteria justifying ECMO use, and outcome were compiled. Survival was defined as being discharged home.

The indication for ECMO was respiratory failure unresponsive to conventional therapy in infants deemed at great risk of dying. Criteria used to identify these infants were:

1. Alveolar-arterial oxygen gradient ≥ 600 for 12 hours or ≥ 610 for 8 hours.
2. Oxygenation index ≥ 40 on 3 of 5 arterial gases 1/2 hour apart.
3. Acute deterioration defined as PaO2 < 40 torr for 2 hours.

Infants were excluded from ECMO if: 1) there was evidence of intraventricular hemorrhage on cranial ultrasound; 2) congenital heart disease was diagnosed as the cause of respiratory failure and more ap-



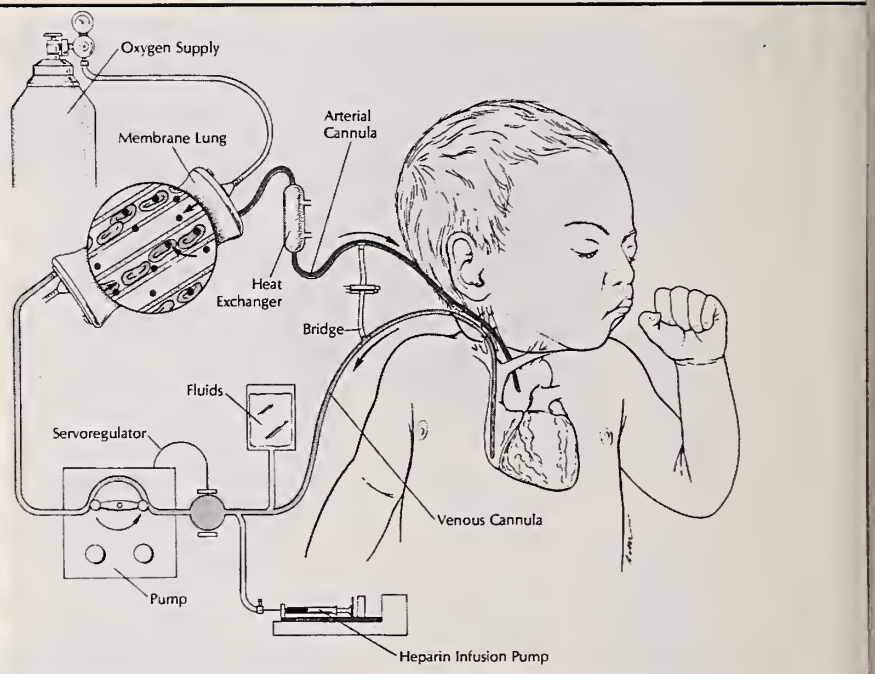


Figure 1 — Catheters are placed in the right atrium via a right internal jugular vein and in the aortic arch via the right common carotid artery. Following cannulation, the patient's catheters are connected to the ECMO circuit and circuit flow is increased to 80% of estimated infant cardiac output. Ventilator rate, pressure, and inspired oxygen concentration are reduced to minimal settings to allow lung rest. Pump flow and membrane oxygen concentration are adjusted to maintain blood gases in desired ranges.

propriate therapy was available; 3) respiratory failure was felt to be irreversible because of sustained high ventilatory pressures and inspired oxygen tension causing changes of bronchopulmonary dysplasia on the chest radiograph; 4) the condition was believed to be non-reversible or incompatible with normal existence after ECMO, i.e., hypoplastic lungs or inoperable congenital heart disease; and 5) the birthweight was less than 2000 gm or they were less than 35 weeks gestation.

Prior to ECMO, all patients received a cranial ultrasound to exclude central nervous system (CNS) anomalies and intracranial hemorrhage (ICH) plus an echocardiogram to identify congenital cardiac disease and evaluate cardiac function. Treatment during this evaluative period was aimed at relieving hypoxemia and included ventilator changes, volume infusion, and pharmacologic manipulation. Infants responding favorably were continued with aggressive treatment. When patients met ECMO criteria, the parents were consulted, risks and options were explained, and parental permission obtained.

Upon completion of the above, the surgical team in the NICU placed catheters in the right atrium via the right internal jugular vein and in the aortic arch via the right common carotid artery. During the operation, the ECMO pump and circuit were prepared. Following cannulation, the patient's catheters were connected to the ECMO circuit and circuit flow increased to 80% of estimated infant cardiac output. Ventilator rate, pressure, and inspired oxygen concentration were reduced to minimal settings to allow lung rest. Pump flow and membrane oxygen concentration were adjusted to maintain blood gases in desired ranges. (Figure 1).

After 48-72 hours, the patients generally began to recover. Pump flow was decreased allowing for a corresponding increase in blood flow through the infant's native lungs. When pump flow measured 5 RPM (~60cc/min), the patient was observed for 8-12 hours and then "bridged." Here the patient, isolated from the ECMO circuit, was supported by conventional ventilation to confirm survival

without ECMO. Once independence from ECMO was proven, the surgical team returned to the NICU and decannulated the infant. Routine NICU care continued except that platelet counts were maintained ≥ 80,000 per cubic mm for 24 hours to reduce the risk of post-ECMO ICH.

Results

Of our first 50 ECMO patients, 42 (84%) were "outborn" and referred from other tertiary nurseries. Eight (16%) infants were born in our facility. Three were delivered to mothers referred to MCG after intrauterine diagnosis of congenital diaphragmatic hernia (CDH). Therefore, only 5 of the 50 ECMO infants would have normally delivered at MCG.

Mean birthweight was 3308 ± 525 grams (mean ± 1 S.D.), with survivors being slightly larger (3374 ± 513 vs 3007 ± 467). The mean gestational age was 40.1 ± 2.2 weeks (mean ± 1 S.D.), with survivors being slightly older (40.2 ± 2.2 vs 39.6 ± 2.2). Twenty-eight of the 50 infants (56%) were male as were 25 of the 41 (61%) survivors (Table 1).

The ECMO infant's diagnoses are listed in Table 2 and reflect primarily the diagnosis of the term infant with respiratory distress. Meconium aspiration with pulmonary hypertension (PPHN) — right to left shunting of blood through the patent ductus arteriosus or foramen ovale — was the leading diagnosis (Figure 2). Thirty of 50 infants (60%) had meconium aspiration with an 86% survival. Other diagnoses — hyaline membrane disease, sepsis, and congenital diaphragmatic hernia — are also associated with PPHN. Occasionally, PPHN occurs independently and is known as idiopathic PPHN. Five patients (10%) had this diagnosis. Three infants had congenital heart disease, one with critical aortic stenosis and two with total anomalous venous return. The diagnosis of critical aortic stenosis was made prior to ECMO but pre-surgical ECMO for perfusion support was needed. The infant was decannulated uneventfully after successful surgery but succumbed 18 hours later secondary to endocardial fibroelastosis. Two infants had total anomalous venous return unrecognized until after decanulation. One patient died; the other was successfully treated.

The criterion for ECMO use are shown in Table 3. When our program began, we used alveolar-arterial oxygen gradients (A-a gradients) as our primary criteria. We later abandoned the A-a gradients for the oxygenation index because 1) hyperventilation therapy for PPHN artificially raised the A-a gradient by reducing the $PaCo_2$, 2) the A-a gradient did not take into account the barotrauma which may occur, and 3) data suggested the A-a gradient was not sufficiently specific to predict infants who would survive without ECMO.

The mean age at ECMO was 53 ± 41.3 hours (± 1 S.D.) and mean ECMO duration was 119.8 ± 64.0 hours (± 1 S.D.). Mortality was weighted toward either very short or extremely long runs.

Of the 50 ECMO patients, 41 survived to be discharged home (82%).

TABLE 1 — Demographics of Infants Treated With ECMO

	Total	*Survived*	*Deaths*
Male/Female	28/22	25/16	3/6
Gestational Age (wk)			
Mean ± 1S.D.	40.1 ± 2.2	40.2 ± 2.2	39.6 ± 2.2
Range	34.5-44	34.5-44	35-43
Birthweight (gm)			
Mean ± 1S.D.	3308 ± 525	3374 ± 513	3007 ± 467
Range	2200-4500	2200-4500	2300-3900
Age on ECMO (hr)			
Mean ± 1S.D.	53 ± 41.3	55.3 ± 43.1	42.1 ± 29.8
Range	9.5-174	11-174	9.5-100
Length of time on ECMO (hr)			
Mean ± 1S.D.	119.8 ± 64	116 ± 51.0	137.2 ± 102.6
Range	16-287	43-230	16-287

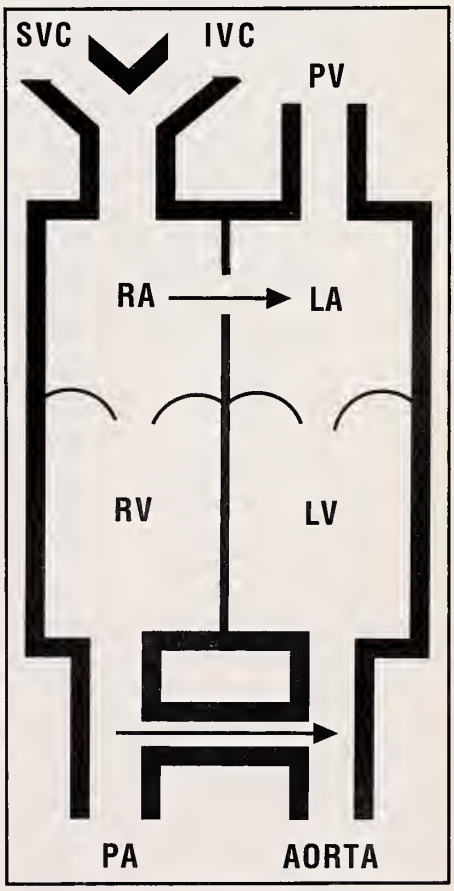


Figure 2 — Due to elevated pulmonary vascular resistance, blood is shunted away from the lungs through the foramen ovale and ductus arteriosus.

TABLE 2 — Diagnosis and Outcome of Infants Placed on ECMO

Diagnosis	*#*	*Survived*	*Deaths*	*% Survived*
1. Meconium aspiration	30	26	4	86%
2. Diaphragmatic hernia	8	5	3	62%
3. Persistent fetal circulation	5	5	0	100%
4. Respiratory distress syndrome	3	3	0	100%
5. Congenital heart disease	3	1	2	33%
6. Group B streptococcal sepsis	1	1	0	100%

An additional three were successfully decannulated, but one suffered a fatal intracranial hemorrhage after being removed from ECMO. Two deaths were associated with congenital heart disease after successful decannulation.

Discussion

The tandem development of neonatal intensive care units and a regionalized system of perinatal care has been instrumental in lowering the neonatal mortality rate in Georgia.[8] Although the greatest contributor to this mortality is pre-term infants, a significant number of term or near-term infants die of respiratory failure. These deaths are particularly frustrating since the illnesses involved are acute, hospitalization relatively short, and morbidity uncommon. In contrast, respiratory failure in pre-term infants is associated with significant pulmonary and neurologic morbidity, followed by prolonged hospitalization after respiratory failure is successfully treated. [9]

Disease processes currently managed with ECMO include neonatal disorders often accompanied by persistent pulmonary hypertension. In this scenario, elevated pulmonary pressure causes persistence of right to left shunts between the atria or through the patent ductus arteriosus. The result is severe and unrelenting hypoxemia often unresponsive to management (Figure 2).

In our series, meconium aspiration with or without PPHN was the most common ECMO diagnosis. Although obstetrical and delivery room management has been instrumental in reducing the incidence and severity of this disorder, they have not been uniformly successful in preventing its occurrence.[10] Cases of fatal meconium aspiration continue to occur secondary to in utero aspiration, particularly when associated with sepsis and even when proper airway management techniques are employed at birth.[11] When these infants are unable to be managed conventionally, we believe ECMO is the alternative.

Although not as frequent as MAS, congenital diaphragmatic hernia (CDH) deserves special mention. Potentially lethal pulmonary hypoplasia may result from the in utero presence of abdominal viscera in the thoracic cavity. However, a reversible cause of hypoxemia frequently complicating postoperative management of CDH is PPHN. ECMO has been successful in this clinical setting but its success, in our experience, has been compromised by failure to employ ECMO early in CDH management.[12] Because of deaths between infant delivery and use of ECMO, we now recommend, should the diaphragmatic defect be identified prenatally, that the mother be referred to an ECMO center for delivery. If the infant is delivered and treated at a non-ECMO center, we recommend transfer to an ECMO center as soon after treatment as possible.

Other conditions amenable to ECMO include respiratory distress syndrome/hyaline membrane disease (RDS) in term or near-term infants and sepsis. Although RDS may eventually be managed with artificial surfactant,[13] sepsis of the newborn, because it is often associated with cardiovascular collapse, may be appropriately managed with ECMO. ECMO not only provides oxygenation but also maintains organ perfusion, allowing for recovery rather than progression to irreversible shock. Although sepsis at one time was considered to be a contraindication to ECMO,[2] we have successfully treated 4 infants with gram negative sepsis.

Initially, we had reservations about ECMO fostered by concerns for the infant's central nervous system. These concerns were the risk of CNS hemorrhage, adequacy of CNS perfusion after common carotid artery ligation, and potential risk to the developing brain. Although CNS hemorrhage has not been a frequent complication with our patients, the rate of ECMO-associated CNS hemorrhage in our first 50 patients was 18% (9 of 50) and was a cause of death in 2 patients.

Taylor et al. have reported perfusion of the right cerebral hemisphere after right common carotid artery cannulation is maintained via the circle of Willis.[14] We have witnessed an increased incidence of left focal seizures after litigation but believe these events may represent already existing CNS insults.[7] Of the survivors 2 years of age or older, approximately 65% are judged to be completely normal, and approximately 10% have significant neurologic or developmental handicap. These favorable outcomes, improved survival, and low morbidity rates are extremely encouraging. Eventually, they may lead to a loosening of ECMO utilization criteria.

The selection of infants to be placed on ECMO is controversial. We prefer to support infants with-

out ECMO, but the difficulty is identifying those infants who will fail conventional management. We currently employ the oxygenation index as our major criterion. We believe this to be more specific in identifying infants who will survive with conventional management while maintaining the sensitivity to identify infants who will require ECMO.

Under our current standard of care, we employ all accepted techniques and maneuvers to achieve adequate oxygenation and avoid ECMO use. Our enthusiasm to treat patients conventionally has resulted in less than half of our referrals reaching ECMO. However, we believe some neurologic handicaps exhibited on follow-up reflect damage related to aggressive conventional treatment. Because aggressive treatment may not be most beneficial to these infants and in light of satisfactory outcomes in our ECMO program, we may alter our selection criteria and use ECMO earlier in these infants.

Advances in obstetrical and delivery room management and development of surfactant replacement will likely reduce the need for neonatal ECMO. We believe ECMO will see increased use in other clinical settings. There has already been successful use of ECMO to support left ventricular function in infants and children after cardiac surgery.[15] Criteria are also being developed for ECMO use in pediatric respiratory failure.[16] Gattiano has also reported successful use of a modified ECMO in adults with respiratory failure.[17]

We have now treated 92 neonates with this technique, with an overall survival of 86%. We will be broadening our program during 1990 to include pediatric respiratory failure and post cardiac surgery patients. Equally exciting will be the use of a new appliance during the coming year which allows ECMO without right common carotid artery sacrifice.

We believe the use of ECMO is in its infancy and will find increasing use throughout pediatrics. The successful implementation of this program for neonates at the Medical College of Georgia is only the first step in its full utilization.

TABLE 3 — Criteria Used to Qualify Infants for ECMO

	Number	*% of Total*
A-a $do_2 \geq 600$ for 12 hours	24	48
A-a $do_2 \geq 610$ for 8 hrs	13	26
Oxygenation Index of 40 or greater	10	20
Acute deterioration	12 *	24

A-a do_2 is the alveolar partial pressure of oxygen less the arterial partial pressure of oxygen. It is calculated by the following formula:

$$A\text{-}a\ do2 = (760 \times FiO2)\text{-}(47 + PaCO2/.8)$$

Oxygenation index is obtained by the following formula:

$$\text{Mean Airway Pressure/Post-Ductal } PaO2 \times 100$$

This criterion was achieved when 3 of 5 arterial samples were 40 or greater.
*Total greater than 50 because some infants met more than one criteria.

The selection of infants to be placed on ECMO is controversial. We currently employ the oxygenation index as our major criterion.

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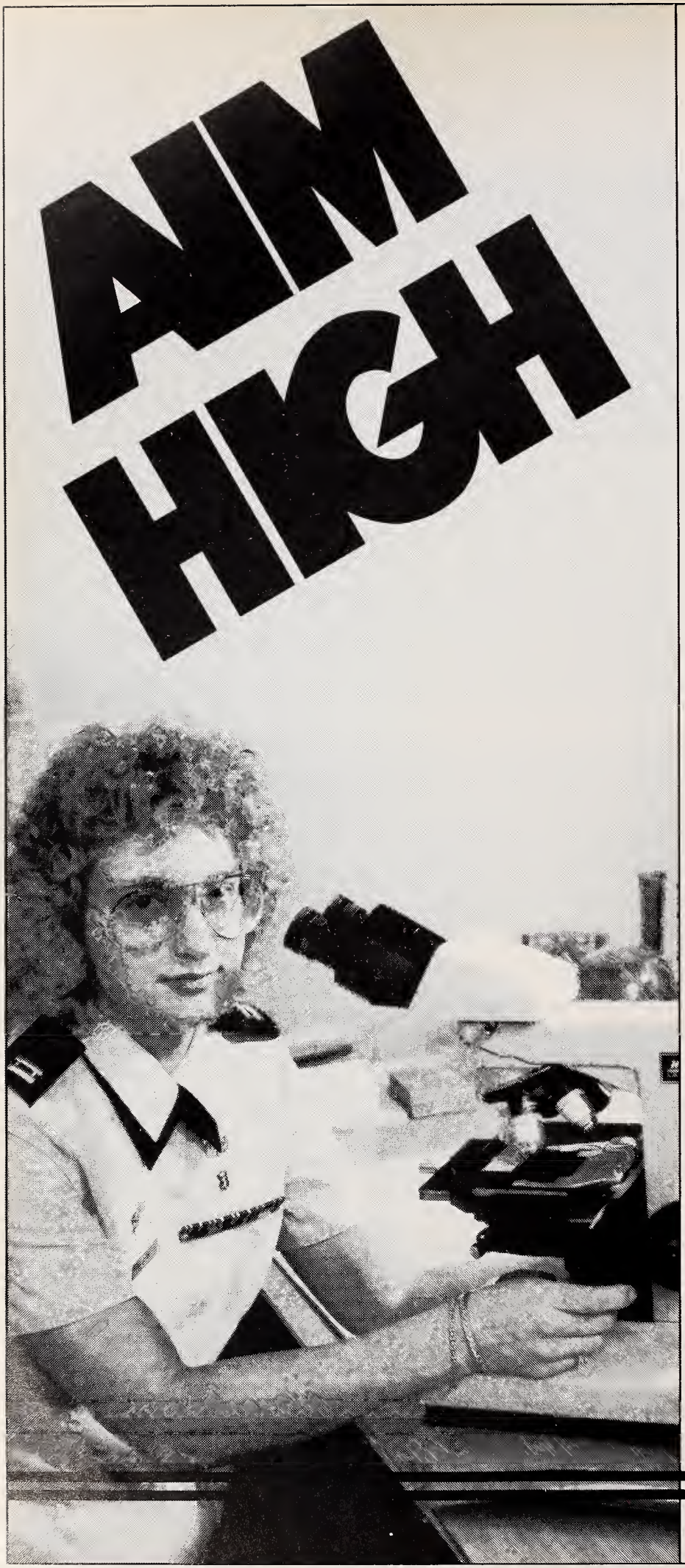

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Concerns About Adjuvant Chemotherapy for Breast Cancer

C. Barber Mueller, M.D.

Introduction

THE PAST 2 decades have seen the testing of the idea that adjuvant chemo- or hormonal therapy may eliminate some or all of the micrometastases present at the time of definitive surgical resection of breast cancer.[1] In its early years, cytotoxic adjuvant therapy was given to destroy circulating cancer cells diffused as a result of the operation. Its current aim is to control distant micrometastases, not local disease,[2] and the ultimate measure of its success will be found in survival increases of sufficient size to outweigh any treatment-related morbidity. However, survival data require a long time to develop, and measurement of the "disease-free interval" has become conventional, recognizing that a patient who gets recurrent disease has probably not been "disease free" but rather "symptom free."

The design of clinical trials of adjuvant therapy has been well worked out, and most trials now have a considerable degree of rigor in randomization, observation, and collection of data. But the reporting of data is complicated, involving statistical interpretation of what has happened to a group of patients. Most trials report by actuarial or "life table" analysis, and a simple understanding of this statistical maneuver should be available to everyone who reads the tables and looks at the graphic display.[3] The graphic display and statistical significance should always show the number of individuals at risk in the final year, as well as in the initial year, for confidence limits widen as the number of individuals gets fewer.

When two groups are compared the reporting of any benefit in survival, length of disease-free state, or rate of local recurrence may be done in one of two ways. One is the actual benefit, which gives the percent of women benefited. The graphic display of any two curves makes it easy to see differences. The other method is relative reporting, in which the difference between the rates of death or relapse in the two arms is expressed as a percentage of the rate of death or relapse in the control arm, yielding a "risk reduction" figure. For example, if the control arm showed 35% mortality at 5 years and the treatment arm showed 28% mortality, relative reporting would indicate a 20% [(35%-28%)/35%] reduction in mortality. Relative risk reduction ratios are universally used to report benefit. The actual benefit is seen in 7% of women — a 7% benefit, not 20%.

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B-05 and Subset Analyses

Eighteen years ago, the National Surgical Adjuvant Breast Project (NSABP) moved to its fifth clinical trial, protocol B-05, a study of 349 patients comparing L-PAM vs. placebo, which led to mandated adjuvant chemotherapy for all women with stage II breast cancer. A preliminary report in 1975[4] was followed in 1985 by a 10-year report.[5] There was no significant survival difference between the two groups.

Eight subgroups were identified. The premenopausal subgroup with 1-3 positive lymph nodes (63 patients) had a statistically significant improvement in survival with administration of L-PAM. This subset was selected for analysis *after* initial randomization, and there is no report to certify that the treated and nontreated subsets were truly equivalent. The assumption was made that since initial randomization gave two equal groups, there would also be effective randomization in the subgroups for those factors that determine survival.[3] However, if only four women in either of the subgroups differed in one prognostic factor, the difference between the placebo and treated arms would not have been statistically significant.

Tamoxifen

Many trials have tested

tamoxifen as adjuvant chemotherapy. Early observations confirmed its usefulness in both pre- and postmenopausal patients with disseminated breast cancer. Its role as adjuvant treatment in primary breast cancer is now beginning to be defined. In the U.S., the tamoxifen effect is generally observed only with a combination chemotherapy regimen.

A meta-analysis done by the Early Breast Cancer Trialists' Collaborative Group[7] reviewed 28 trials involving tamoxifen given for 1, 2, or more years. The authors concluded that tamoxifen given to premenopausal women as adjunctive therapy has no measureable effect on survival. The analysis also suggested that tamoxifen given to postmenopausal women provides a 9-month survival benefit to approximately 6% of women at 4 years. Side effects of tamoxifen given to postmenopausal women are relatively small. The duration for which it should be given is not yet known, and there are no data available to indicate whether or not tamoxifen is effective in the period between recurrence and death in patients who received it as adjuvant therapy. Nor is it known whether it is better to treat every woman with tamoxifen — probably for life — or to reserve its use for those in whom disease recurs.

The Disease-Free Interval — Scientific or Spurious?

Survival figures require a long time to develop, and reporting of the disease-free interval has become conventional. It was hoped that the longer the time between treatment and recurrence, the longer would be the time between recurrence and death, but this has yet to be shown. Reports are difficult to interpret because the various studies do not agree on how carefully local or regional recurrent disease is separated from distant disease. The disease-free interval is something determined by the physician, and the more aggressive is the hunt for metastases, the shorter will be the disease-free interval. Many studies have been published that show increases in the disease-free interval without changes in survival.[1, 8-11]

Studies on Node-Negative Breast Cancer Patients

The February 23, 1989, issue of *The New England Journal of Medicine* contained the results of four studies on the administration of systemic adjuvant chemotherapy to patients with node-negative breast cancer.[8-11] All four showed an increase in the disease-free interval but no change in survival. The two studies from NSABP concluded that, "a physician's bias should not deny a patient the option to accept or reject the opportunity to receive the benefit," and led to an NCI alert.[12] The Ludwig Institute investigators concluded that their study "provides evidence of effectiveness of short-term treatment." But the authors of the Cleveland study wrote that they "do not believe all patients with node-negative breast cancer should be subjected to adjuvant therapy."

NSABP protocol B-13[10] reported on 679 estrogen receptor-negative patients, half of whom were treated with 12 courses (one per month) of methotrexate, 5-fluorouracil, and leucovorin. This regimen produced a 9% difference in disease-free survival at four years, but no difference in overall survival.

To determine a benefit-to-harm ratio, we assume that 12 cycles of chemotherapy would leave each woman feeling ill at least 1 week per month, for a total of 3 months. For 100 treated women, this constitutes 300 months of illness. The gain that was achieved was a delay in recurrence in 9% of the women of approximately 14 months, or 126 months of benefit per 100 patients. This delay in recurrence may be a statistically significant outcome, but it is clinically unacceptable. Failure to measure a harm/benefit ratio leads to conclusions about benefit that are more emotional than scientific.

"Adjuvant chemotherapy, the chemical treatment of women who are otherwise well, raises profound ethical issues. Causing a well woman to become ill is something very visible."

Ethical Considerations in Adjuvant Chemotherapy

Adjuvant chemotherapy, the chemical treatment of women who are otherwise well, raises profound ethical issues. Causing a well woman to become ill is something very visible. Benefit, on the other hand, is never seen in an individual woman, since the benefits of adjuvant therapy are seen only in group statistics. The

ethical concerns that surround this problem have been addressed by many individuals from several perspectives. The two extremes are the utilitarian ethic[13, 14] and the Hippocratic doctor/patient ethic.[15]

The utilitarian ethic advocates actions that produce the greatest aggregate benefit and may be expressed as the "greatest good to the greatest number." The net benefit and net harm may be determined in the aggregate, but who gains and who loses is not known.

Since clinical trials operate with the utilitarian ethic, benefits and harms to individual subjects are lost in the group outcome. NSABP reports the various illnesses occasioned by adjuvant treatment (nausea, diarrhea, alopecia, leukemia, etc), but does so without a time component, that is, without subtracting time from a patient's well-being for adverse effects. There has been no attempt to balance the aggregate time of illness against the aggregate gain in disease-free survival. This is difficult but not impossible to address in clinical trials.

Clinical trials are *not* the practice of medicine. Individuals in these trials are subjects, not patients, and by definition those who conduct trials are experimenters. The ethical constraints that deal with this experiment-subject relationship are clearly expressed in the Nuremberg code,[16] the Declaration of Helsinki,[17] and the National Institutes of Health guidelines.[18] Ethical constraints on the doctor who treats a patient, however, are uniquely individual, not group oriented. These have found expression for 2,500 years in the Hippocratic and later Percival traditions.[13] The central regulatory themes include the admonition, "Do no harm."

'It is probably not in the classic tradition of ethical medical practice to recommend to any woman a drug or treatment that can never be seen to be to her benefit, unless the outcome from that therapy is so overwhelmingly superior that it no longer requires statistical analysis.'

It is probably not in the classic tradition of ethical medical practice to recommend to any woman a drug or treatment that can never be seen to be to her benefit, unless the outcome from that therapy is so overwhelmingly by superior that it no longer requires statistical analysis. The current rush to adjuvant chemotherapy has neither a scientific, clinical, or ethical rationale. After 20 years, the evidence seems to say NO.

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Nitrate Tolerance

Robert C. Schlant, M.D.

NITRATES WERE FIRST used for the treatment of angina pectoris in 1867 in the form of amyl nitrate.[1] Nitroglycerin, which was first used for angina pectoris in 1877,[2] has since become one of our most widely used cardiovascular medications. In addition to being administered sublingually, nitroglycerin is used in the form of ointment or patches for transdermal absorption, as a buccal tablet, as an oral spray, and as a slow-release oral preparation. In addition, many long-acting nitrate preparations are available that have prolonged antianginal and antiischemic effects.

‘The phenomenon of “nitrate tolerance” or a reduced extent and duration of effects, was thought to have little clinical significance until about 1980.’

The fact that individuals develop tolerance to nitroglycerin was first noted during World War I in workers working in munition plants. These workers frequently had severe headaches, nausea, and other side effects when they returned to work on Mondays after not working for the weekend. It has also been noted for many years that patients taking nitroglycerin for angina pectoris often have more marked headache and light-headedness when first taking nitroglycerin after not having taken any for a number of days.

In general, however, the phenomenon of “nitrate tolerance,” or a reduced extent and duration of effects, was thought to have little clinical significance until about 1980. Since then, however, it has been the subject of numerous studies which have shown that nitrate tolerance can develop quite rapidly and that it can significantly decrease the therapeutic effects of many forms of nitrate therapy.[3-10] At the same time, these studies have suggested potential ways to decrease or prevent the development of nitrate tolerance.

Tolerance is more likely to occur with continuous or nearly continuous therapy, as might occur with continuous intravenous nitroglycerin; with four times a day therapy using a long-acting nitrate preparation, such as isosorbide dinitrate; with the continuous use of long-acting transdermal nitroglycerin patches; or with the regular use of nitroglycerin or isosorbide dinitrate ointment. Tolerance has been noted in patients receiving nitrates for either angina pectoris or heart failure.

Factors associated with a greater likelihood of developing tolerance include higher dosage, greater frequency of administration, and greater duration of exposure to nitrates. Therapeutic regimens that provide nearly a constant plasma concentration are most likely to lead to the development of tolerance, while those that provide at least some nitrate-free intervals are likely to produce only partial tolerance.

‘Factors associated with a greater likelihood of developing tolerance include higher dosage, greater frequency of administration, and greater duration of exposure to nitrates.’

Much has been learned about the mechanisms by which nitrates work and by which

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tolerance develops. Organic nitrates are converted to nitric acid, which reacts with sulfhydryl-containing compounds to form S-nitrosthiols. These stimulate guanylate cyclase production, which is responsible for the production of cyclic guanosine monophosphate (cGMP). Cyclic GMP may accelerate calcium release from vascular smooth muscle, producing relaxation of contractile smooth muscle proteins. One possible mechanism by which tolerance develops is a reduction in the availability of sulfhydryl groups,

"The most efficient way to avoid or lessen nitrate tolerance is to provide a daily 8-12 hour nitrate-free period. . . . The optimal nitrate-free period should be individualized depending upon the individual patient's pattern of ischemic epidoses."

which leads to decreased production of cGMP and less vasodilatation. To date, however, there are conflicting results from the administration of N-acetylcysteine, which is a source of sulfhydryl groups and theoretically might prevent or decrease the development of nitrate tolerance.

"It is not appropriate to utilize nitrate-free periods when IV nitroglycerin is used in patients with unstable angina or acute myocardial infarction."

Currently, the most efficient way to avoid or lessen nitrate tolerance is to provide a daily 8-12 hour nitrate-free period. For most patients, this period is best from about 7 pm to 7 am. This can be obtained by removing a nitroglycerin patch in the evening and applying a new one early the next morning. Alternately, patients on long-acting oral isosorbide dinitrate can take their medication at 7 am and 2 pm to allow a low plasma level overnight.[6] The optimal nitrate-free period should be individualized depending upon the individual patient's pattern of ischemic episodes. Thus, patients with substantial nocturnal angina should have their nitrate-free period during the daytime. Most patients should have antianginal therapy during their nitrate-free period; this is usually best accomplished by the use of a beta-blocker, calcium antagonist, or both. Other therapeutic principles that help decrease the development of nitrate tolerance include the use of the smallest effective dose, the avoidance of sustained or continuous action formulations when possible, and the less frequent administration of doses.

It should be noted that there is considerable variation between patients in the development of nitrate tolerance and that if a patient's symptoms are very well controlled on a given regimen, it may not always be necessary to institute a nitrate-free period. In addition, it is not appropriate to utilize nitrate-free periods when intravenous nitroglycerin is used in patients with unstable angina or acute myocardial infarction, although such therapy may require progressively increasing dosage after 24-48 hours.

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AMA Enjoined From Boycotting Chiropractors

Robert N. Berg

In 1976, four chiropractors brought an antitrust action against the American Medical Association (AMA), along with several other defendants, including the American College of Physicians and what was then called the Joint Commission on Accreditation of Hospitals (JCAH), contending that the defendants had unlawfully conspired and combined to boycott the practice of chiropractic throughout the United States. Nearly 14 years later, following two trials and two appeals, the apparent final result is that the AMA has been enjoined from engaging in actions, long since ceased, constituting an unlawful boycott against chiropractors. In this month's Legal Page, we review the long and well-publicized history of *Wilk v. American Medical Association.*[1]

Wilk I: The Courts Disagree on the "Patient Care Defense"

The *Wilk* case was brought by four licensed chiropractors and originally sought damages and an injunction against the AMA and others. The plaintiffs' primary claim was that the defendants engaged in an unlawful conspiracy to eliminate the profession of chiropractic by refusing to deal with chiropractors. The plaintiffs contended that the boycott was accomplished through the AMA's adoption of what was known as "Principle 3" of the AMA's Principles of Medical Ethics, which prohibited medical physicians from associating professionally with "unscientific practitioners." According to the plaintiffs, the AMA implemented this boycott as early as 1966 by labeling chiropractors as "unscientific practitioners," and then advising AMA members and others that it was unethical for medical physicians to associate with chiropractors. (The AMA modified its position on chiropractic several times between 1977 and 1980, in each case stepping back from its prior position.)

"Following a lengthy trial, the jury returned a verdict in favor of the defendants. On appeal, however, the Seventh Circuit Court of Appeals reversed the jury verdict, holding that the trial court had allowed the jury improperly to consider whether the AMA's motives generally were in the public interest. . . ."

Following a lengthy trial, the jury returned a verdict in favor of the defendants. On appeal, however, the Seventh Circuit Court of Appeals reversed the jury verdict, holding that the trial court had allowed the jury improperly to consider whether the AMA's motives generally were in the public interest, rather than the more limited consideration of whether the AMA's motives were in the best interest of patient care.[2] Accordingly, the Court of Appeals ordered a new trial.

Immediately prior to the second trial, the plaintiffs abandoned their claim for damages, instead seeking only injunctive relief. Thereafter, the trial court conducted a lengthy bench trial and concluded that the AMA, through its Principles of Medical Ethics, had unreasonably restrained trade in violation of the Federal antitrust laws. The trial court therefore granted the plaintiffs' request for injunctive relief, ordering the AMA to arrange publication of the court's opinion in the *Journal of the American Medical Association,* to mail the court's order to all AMA members, and to revise the current opinions of the AMA's Council on Judicial and Ethical

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Affairs so that the AMA's present position on chiropractic was stated in a separate provision, with a heading and index references referring to chiropractors.[3] The AMA appealed the trial court's decision to the Court of Appeals, which affirmed that decision in an opinion issued on February 7, 1990.

Wilk II and III: The Courts Struggle to Structure Relief Designed to Redress Past Antitrust Violations

In reaffirming the lower court's decision, the Court of Appeals dealt with a number of issues, including (i) whether the AMA's conduct constituted an unreasonable restraint of trade; (ii) whether the AMA's conduct was protected activity, under the "Noerr-Pennington" doctrine or the First Amendment; (iii) whether the AMA's activities were justified under the "patient care defense"; and (iv) whether the injunctive relief ordered by the trial court was appropriate. In each case, the Court of Appeals upheld the trial court's analysis and decision.

Unreasonable Restraint of Trade. The primary question in the *Wilk* case was whether the AMA's activities constituted an unlawful boycott which unreasonably restrained trade. The trial court had found that, as far back as 1966, the AMA had labelled the practice of chiropractic as "an unscientific cult," and had taken certain actions (including the adoption of Principle 3 of the Principles of Medical Ethics) in order to prevent medical physicians from referring patients to chiropractors and from accepting referrals of patients from chiropractors, to prevent chiropractors from obtaining access to hospital

"The primary question in the* Wilk *case was whether the AMA's activities constituted an unlawful boycott which unreasonably restrained trade."

diagnostic services and membership on hospital medical staffs, to prevent medical physicians from teaching at chiropractic colleges, and to prevent any cooperation between medical physicians and chiropractors in the delivery of health care services, all as part of a more broad effort to eliminate the practice of chiropractic. In addition to these findings, the trial court held that the AMA, through its members, had the power to raise prices or limit output in a relevant market consisting of "the provision of health care services to the American public nationwide, particularly in the care for the treatment of musculoskeletal problems."[4] From this, the trial court found that the AMA had exercised its market power improperly to boycott chiropractors, a violation of the antitrust laws.

The trial court also found that the AMA's activities put chiropractors at a significant competitive disadvantage. For example, the Court found that the AMA's activities imposed higher costs on chiropractors by forcing them to pay for their own X-ray equipment, rather than obtaining X-rays from hospital radiology departments or radiologists in private practice. The Court of Appeals affirmed these findings and upheld the trial court's determination that the AMA's activities constituted an unreasonable restraint of trade, in violation of the Sherman Act.

Protected Activities. The "Noerr-Pennington" doctrine protects otherwise unlawful activity by allowing businesses and other associations to join together to petition legislative bodies, administrative agencies, or courts, even if those actions have anti-competitive consequences.[5] The AMA sought to utilize this doctrine by claiming that its activities constituted nothing more than attempts to influence legislation on the state and federal levels and to inform the public of the nature of chiropractic. The trial court

"The trial court found that the AMA could satisfy its concerns for the scientific method of patient care in a manner less restrictive of competition than a wholesale boycott of the entire chiropractic profession."

rejected this defense, however, because of what it viewed as substantial evidence that the AMA's acts were aimed primarily at achieving the boycott's goal of eliminating chiropractic, rather than at achieving legislative action. On appeal, the Seventh Circuit affirmed this finding, as well, noting that the AMA's activities "were not aimed at obtaining legislative action. They were instead aimed at medical physicians and hospitals, cautioning them that it was unethical and indeed dangerous

(the obvious inference from receiving health care from an unscientific cult) to associate professionally with chiropractors."[6]

The AMA also contended that its activities were protected by the First Amendment to the U.S. Constitution, as a form of free speech. Both the trial court and the Seventh Circuit rejected this argument, however, finding that the First Amendment could not be construed to protect activity which otherwise constituted an unlawful boycott under the antitrust laws.

Patient Care Defense. In the first *Wilk* appeal, the Seventh Circuit formulated what became known as the "patient care defense," a controversial theory (not generally accepted by other courts in subsequent cases) which generally provides that a defendant may justify otherwise anti-competitive activity by showing that it acted because of a genuine, and reasonable, concern for scientific method in patient care and that it could not adequately satisfy this concern in a way that was less restrictive of competition.[7] In the second trial, the District Court found that the AMA had failed to satisfy its burden of proof with respect to the patient care defense, for two reasons: First, the Court found that, while the AMA's activities could be supported by evidence, existing at some point in time, that the practice of chiropractic was unscientific, there was also a significant amount of evidence, at various later times, that the practice of chiropractic was effective in treating certain kinds of problems, such as back injuries. As a result, the Court determined that, at some point during the AMA's boycott, there was no longer an objectively reasonable concern that would support a boycott of the entire chiropractic profession. In addition, the trial court found that the AMA could satisfy its concerns for the scientific method of patient care in a manner less restrictive of competition than a wholesale boycott of the entire chiropractic profession.

On appeal, the Seventh Circuit upheld the trial court's decision. Essentially, the Seventh Circuit found untenable the AMA's position that the "least restrictive" method of expressing its concern over the unscientific nature of chiropractic practice was to engage in a 14-year boycott of the chiropractic profession.

Scope of Injunctive Relief. Having determined that the AMA's activities constituted an unlawful boycott of the practice of chiropractic, the trial court was then required to structure an appropriate injunctive remedy. This was somewhat difficult, in light of the fact that, according to the trial court, the AMA's boycott had ended in 1980, more than 7 years prior to the time when the trial court was to issue its injunction. Nonetheless, the Court found it necessary to issue a broad injunction "to assure that the AMA does not interfere with the right of a physician, hospital, or other institution to make an individual decision on the question of professional association."[8] On appeal, the Seventh Circuit affirmed the trial court's decision, in the face of vehement opposition from the AMA. In particular, the Seventh Circuit rejected the AMA's arguments that it had adopted new ethical principles, "entirely independent" of the *Wilk* lawsuit; the Seventh Circuit also rejected the AMA's contention that there were no "lingering effects" from the boycott which served to impose continuing competitive disadvantages on chiropractors. Accordingly, the Seventh Circuit affirmed the requirements to be satisfied by the AMA, as imposed by the trial court.[9]

Conclusion

Antitrust cases typically are time-consuming, expensive propositions, and the *Wilk* case is no exception. More than 14 years after the initial *Wilk* complaint was brought — and more than 10 years after, the trial court conceded, the AMA's boycott of the chiropractic profession ceased — the Seventh Circuit has affirmed an order which, in essence, requires the AMA to cease doing what it in fact ceased doing in 1980. Nonetheless, the *Wilk* case exemplifies the difficulties which courts have in dealing with actions taken by organized medicine (or any organized profession) in the name of patient care. The *Wilk* case also exemplifies the difficulties which organized medicine has in taking such actions, where there is a likely potential adverse impact upon other groups of competing professionals

Notes

1. _____ F.2d. _____ (7th Cir., February 7, 1990) ("Wilk III").
2. *Wilk v. American Medical Association,* 719 F.2d 207 (7th Cir. 1983) ("Wilk I").
3. *Wilk v. American Medical Association,* 671 F.Supp. 1465 (N.D. Ill. 1987) ("Wilk II").
4. *Wilk II, supra,* 671 F.Supp. at 1478.
5. *See, Eastern Railroad Presidents' Conference v. Noerr Motor Freight, Inc.,* 365 U.S. 127 (1961); *United Mine Workers v. Pennington,* 381 U.S. 657 (1965).
6. *Wilk III, supra,* _____ F.2d. at _____.
7. *Wilk I, supra,* 719 F.2d. at 227.
8. *Wilk II, supra,* 671 F.Supp. at 1507.
9. In addition to the rulings described above, the Seventh Circuit also affirmed the trial court's decision dismissing the ACP and JCAH, on the grounds that those defendants had acted independently, rather than in furtherance of the AMA's boycott. *Wilk III, supra,* _____ F.2d. at _____.

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STYLE — In general, articles can be 8-10 pages in length. For exceptional circumstances, contact the Managing Editor. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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MRI UPDATE

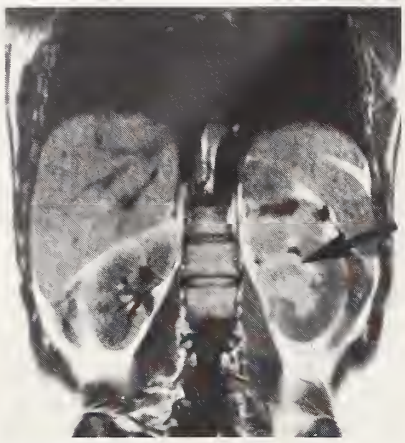

Figure 1

Figure 2

Figure 3

CLINICAL HISTORY: This is a 25-year-old female with complaints of left sided flank pain, nausea, and vomiting.

FINDINGS: Figure 1 represents a coronal T1-weighted image through the kidneys. A lobulated soft tissue mass conforming to the approximate shape of the left renal pelvis and the lower pole collecting system can be identified (large arrow). Signal intensity is intermediate and there is a central area of decreased signal intensity probably representing necrosis. Figure 2 is a sagittal image through the left kidney. In this projection, the soft tissue mass is comma shaped and can be identified extending from the left renal pelvis into the proximal left ureter (small arrows). Figure 3 is a T2-weighted image which exhibits increased signal intensity in the periphery of the mass and central decreased signal intensity. A curvilinear low signal structure lies medial to the mass and is felt to represent the left renal vein displaced by the mass. The vein appears to be patent as evidenced by the low signal intensity indicative of flowing blood (small arrows). No adenopathy is identified. There is no evidence of extension of the mass beyond the margins of the left renal pelvis or the proximal left ureter.

MR IMPRESSION: The location and shape of the soft tissue mass is typical for a transitional cell carcinoma.

MR NOTES: MR of the kidneys is a noninvasive procedure yielding both static and dynamic information about the pathologic process in question. In this case, the MR images defined the presence of the soft tissue mass in the left kidney, the confinement of the soft tissue mass to the left renal collecting system and the proximal left ureter, and the lack of invasion into the kidney and the adjacent pararenal soft tissue structures. In addition, the MR scan demonstrated that there is no evidence of thrombosis of the left renal vein nor is there evidence of tumor into the vein. MR imaging of the kidney is a noninvasive procedure allowing both anatomic identification of renal masses, staging of the extent of those renal masses, and determination of the presence or absence of renal vein involvement for surgical planning.

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COVER

Original art by Isabelle Melchior, of Paris, France.

Dear Editor:
(Editor's Note: These remarks refer to the article "Determinants of Primary Therapy of Early Stage Breast Cancer" published in the June, 1990, Journal of the MAG.)

The primary treatment of early breast cancer continues to be controversial. Which patients have a breast conserving procedure, and who makes the decision? I would compliment the authors on their detailed analysis of this question. There is certainly need for physicians to understand the dynamics of this issue. The major determining factors in the treatment selection process includes 1) technical consideration of permissive criteria, 2) physician preference, 3) patient preference, 4) availability of treatment facilities, and 5) cost consideration.

The major determinate of treatment selection in this study was physician dominated. Physician preference most often prevailed over other consideration. The data from this study indicates that the oncologically trained, experienced breast cancer surgeons prefer more aggressive treatment plan than lumpectomy and radiation. It is also strikingly apparent that the surgeon who treats breast cancer occasionally, less than 3 cases per year, is 14 times more likely to opt for lumpectomy and radiation (35% compared to 2.4%) rather than mastectomy.

This paper reflects a pattern at Emory University at Crawford W. Long hospital and should not be used to suggest this is a state wide pattern. Treatment selection is an evolving process, and I suspect patients will continue to exert more influence in the future. The technical selection criteria will hopefully become more refined as additional data is collected on treatment failures.

Philip Z. Israel, M.D., F.A.C.S., Atlanta

QUOTES

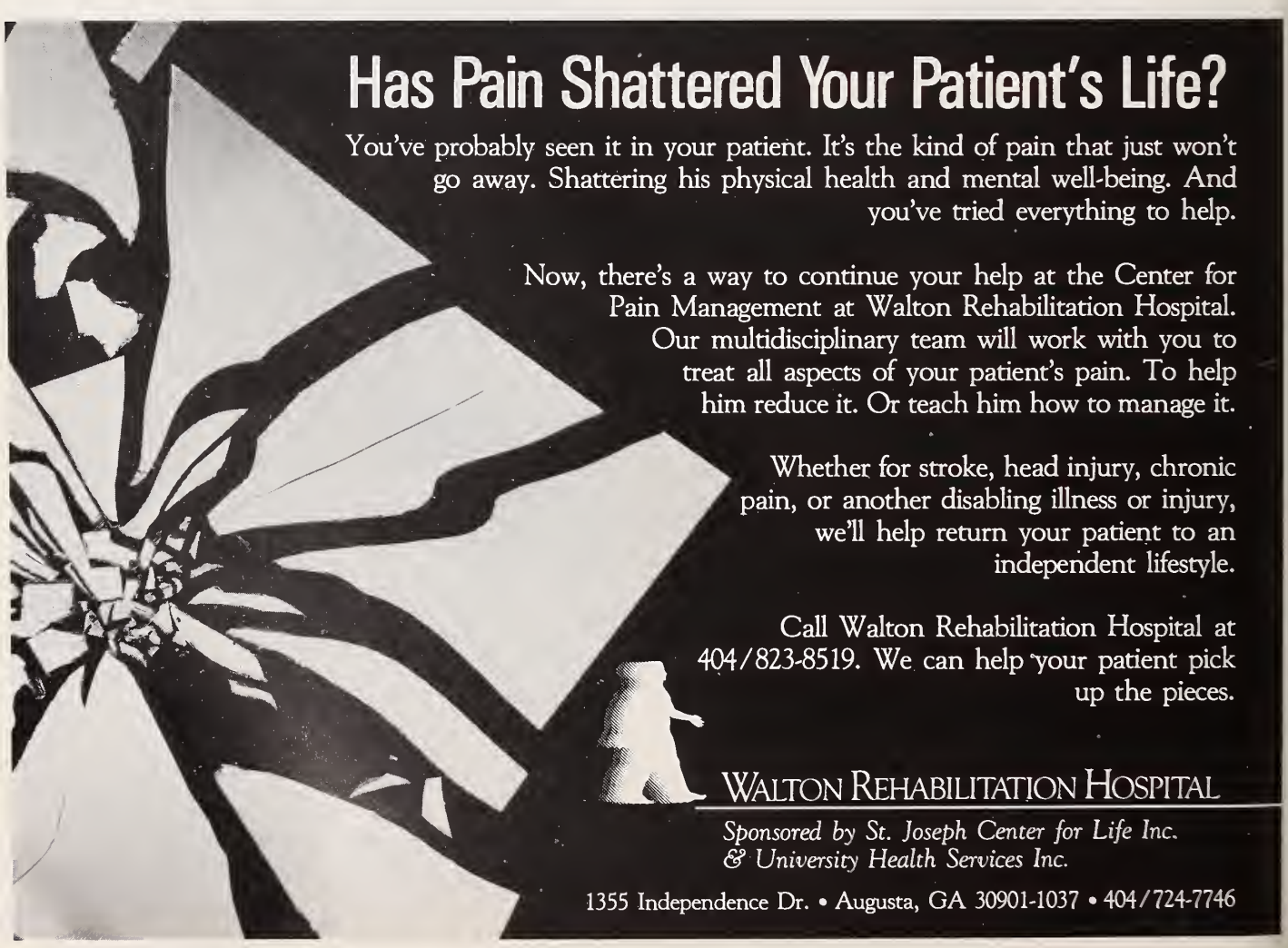
Why can't we build orphanages next to homes for the aged? If someone's sitting in a rocker, it won't be long before a kid will be in his lap.
CLORIS LEACHMAN

I have a very strong feeling that the opposite of love is not hate — it's apathy.
LEO BUSCAGLIA

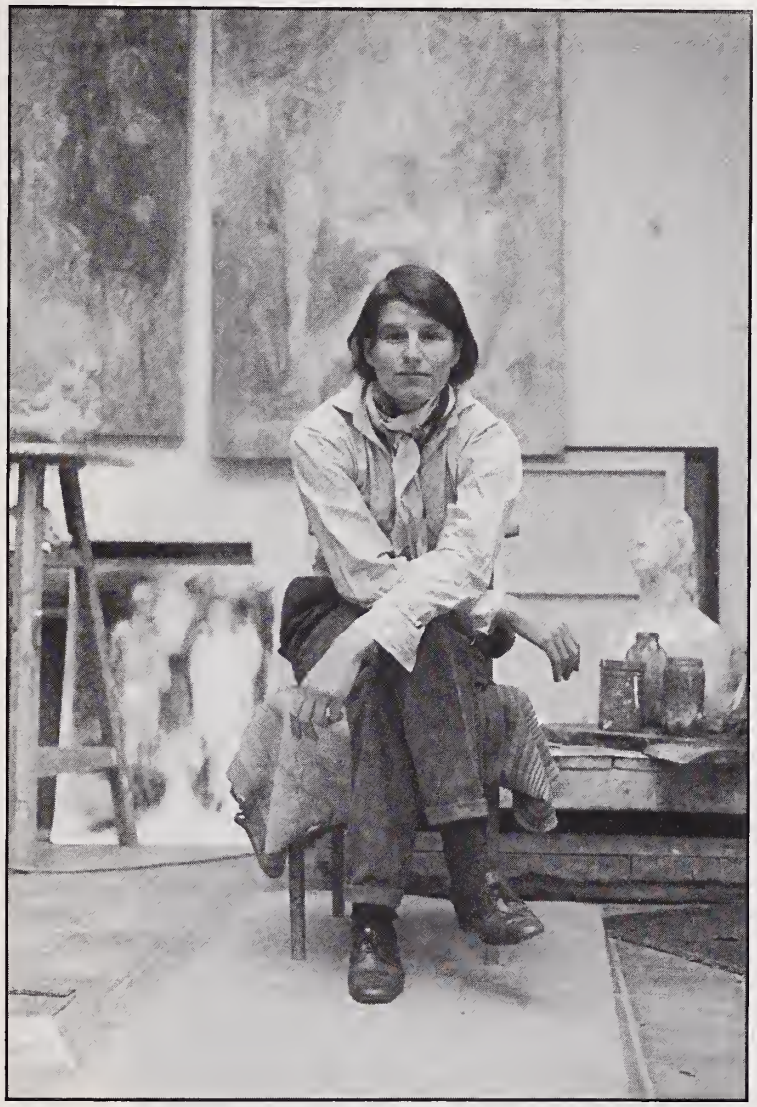
We abuse land because we regard it as a commodity belonging to us. When we see land as a community to which we belong, we may begin to use it with love and respect.
ALDO LEOPOLD

The great need for anyone in authority is courage.
ALISTAIR COOKE

Praise is the best diet for us, after all.
SYDNEY SMITH



About the Artist: **Isabelle Melchior**



When looking at Isabelle Melchior's paintings, one is first struck by their unique beauty drawn from Impressionism, abstraction and expressionism. But Melchior does not stop with the established. She forges ahead to explore her personal and contemporary world, the world of people and their relationships.

Isabelle Melchior is a graduate of the prestigious Ecole Nationale Superieure des Beaux-Arts in Paris, France. In 1973 while at the Ecole, she won the national drawing prize, Prix de dessin David Weill. Encouraged by the renowned sculptor, Cesar, Melchior made sculpture her first love and in 1980 was awarded the Prix de Rome for her sculpture and drawing. By winning this coveted international prize, she received a grant for two years of personal study at the Villa Medicis in Rome, Italy. Upon returning to Paris in 1982 she chose to forfeit a promising career as a sculptor in favor of pursuing another love, painting. Since this time she has painted, and the result of this labor is being richly rewarded in the United States and Europe with a growing following of collectors.

Today, Isabelle Melchior spends her time between Paris and Prague, Czechoslovakia, where her husband serves as the French Cultural Attache to Czechoslovakia. Her recent works, including "Les mots" or "Words" featured on the cover, are about the communication, distance and intricacy of relationships between strangers, friends and families. At once intimate and grand, her subjects are simple, the stories old and the message is subtle; they are at the service of her painting. With her gentle power she draws us into her world, one of greatness, authenticity, hope, caring and plenitude.

Works by Isabelle Melchior may be viewed at Galerie Timothy Tew, TULA, D2, 75 Bennett Street, NW, Atlanta, Georgia 30309, telephone: (404) 352-0655.

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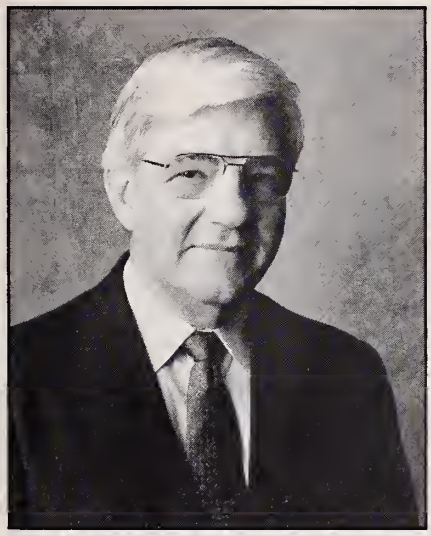


William C. Collins, M.D.

The Politics of Aging

"Don't look back — somebody might be gaining on you."
SATCHEL PAIGE

"Grow old along with me — the best is yet to be. The last of life for which the first was made."
ROBERT BROWNING, *Rabbi Ben Ezra*

THE RECENT DEATH of a dear friend, the early retirement of two other physicians of a similar age in my medical community, and the personal acquisition of aches and pains that somehow were not present in years gone by naturally turn me to the process of aging. It is a process that begins the day we are born in to this world and continues until the very day we exit. It is a fact that we either age or we die. Philosophers, scholars, and the common man have thought on this process from time immemorial and they wax eloquently in such writings as Seneca when he said, "We should cherish old age and enjoy it. It is full of pleasure if you know how to use it.

Fruit tastes most delicious just when the season is ending. We, as Americans and certainly we, as physicians, must not only adopt a healthy attitude toward our own aging, but influence the social climate toward appropriate decisions regarding the older citizens in our society. We must help them, and in turn ourselves, enjoy the fruits of their labors in a healthy and appropriate lifestyle and good medical care, should they become needful of such.

In the year 2000, we will have 21,000,000 citizens over the age of 65, and the percentage of our population 65 and over will increase from 12% of our population in 1990 to 24% of the population in 2080. The United States will continue to have to deal with an older retired population whose clear-cut duties in our society have not been defined and, who, more than likely, will live longer than their average compatriot of a number of years ago.

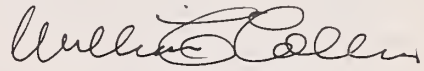
The appropriate medical care of our aging population is a responsibility of the medical profession, but we must also be ready to work with our senior citizens in their lifestyles problems as well as their medical problems. Many times, these are intimately entwined and cannot be separated. The shortage of private custodial health care makes group management facilities such as retirement homes and nursing homes a commonplace solution to elder care as opposed to continued management in an extended family environment.

Study upon study indicates that attitudes concerning aging by those who are aging as well as those who are around older people influence health problems. In a study done by Dr. Alexander Leaf, in conjunction with the National Geographic Society, three regions with high rates of centenarians were studied. Many common factors were found and, above all, many common attitudes. Whether the extreme elderly were found in the Caucasus mountains of Southern USSR, the Indian villages of Ecuador, or in the land of Hunza in Kasimir, several factors were paramount. The older people of all three cultures shared a great deal of physical activity. Active interest in the opposite sex was an important part of longevity. With rare exceptions, only the married obtained extreme age. A feature common to all three cultures was a high social status of the aged. Most of the elderly people studied lived with family and close relatives in an extensive household and occupied a central and privileged position within this group. There was also a sense of usefulness. The aged were esteemed for their wisdom that was thought to derive from long experience and their word in the family group was generally law.

The problems with Medicare and Social Security, the glorification of youth, and the breaking up of the traditional family are putting undue pressure on the senior citizens of our country. They are being used as political footballs by many politicians and bureaucrats. Many, I am sure, feel like society is trying to sweep them under the rug.

We, in medicine, must continue to be the advocates for our older patients. We must not let the politicians or bureaucrats come between us in their care. First, it is our duty; second, it is our pleasure, and; third, to paraphrase Pogo, at some point in time, it is an inescapable fact that we will meet the aged and they will be us.

"He who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of an opposite disposition, youth and age are equally a burden." SOCRATES



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Of Evolving and Survival

"I am convinced that God meant this land for people to rest in, — not to work in. If we were so constituted that life could be an idyll, then this were the place of places for it: but being, as it is, the hottest of battles, — a man might as well expect to plan a campaign in a dream as to make anything like his best fight here."

SIDNEY LANIER
(FROM A LETTER TO MARGARET PEACOCK.)
BRUNSWICK, GEORGIA
APRIL 18, 1875

"To sum up on the origin of our domestic races of animals and plants. Changed conditions of life are of the highest importance in causing variability, both by acting directly on the organisation, and indirectly by affecting the reproductive system. It is not probable that variability is an inherent and necessary contingent, under all circumstances. The greater or less force of inheritance and reversion, determine whether variations shall endure. Variability is governed by many unknown laws, of which correlated growth is probably the most important. Something, but how much we do not know, may be attributed to the definite action of the conditions of life. Some, perhaps a great, effect may be attributed to the increased use or disuse of parts. The final result is thus rendered infinitely complex. . . . Natural selection acts solely through the preservation of variations in some way advantageous, which consequently endure. Owing to the high geometrical rate of increase of all organic beings, each area is already fully stocked with inhabitants; and it follows from this, that as the favoured forms increase in number, so, generally, will the less favoured decrease and become rare. Rarity, as geology tells us, is the precursor to extinction. We can see that any form which is represented by few individuals will run a good chance of utter extinction, during great fluctuations in the nature of the seasons, or from a temporary increase in the number of its enemies. But we may go further than this; for, as new forms are produced, unless we admit that specific forms can go on indefinitely increasing in number, many old forms must become extinct."

ON THE ORIGIN OF SPECIES,
BY MEANS OF NATURAL SELECTION
OR THE PRESERVATION OF FAVOURED
RACES IN THE STRUGGLE FOR LIFE
CHARLES DARWIN

"Black magic, the magic of the primeval chaos, blots out or transmogrifies the true form of things. At the stroke of twelve the princess must flee the banquet or risk discovery in the rags of a kitchen wench; coach reverts to pumpkin. Instability lies at the heart of the world. With uncanny foresight folklore has long toyed symbolically with what the nineteenth century was to proclaim a reality, namely, that form is an illusion of the time dimension, that the magic flight of the pursued hero or heroine through frogskin and wolf coat has been, and will continue to be, the flight of all men. Goethe's genius sensed, well before the publication of the Origin of Species, *the thesis and antithesis that epitomize the eternal struggle of the immediate species against its dissolution into something other: in modern terms, fish into reptile, ape into man. The power to change is both creative and destructive — a sinister gift, which unrestricted, leads onward toward the formless and inchoate void of the possible. This force can only be counterbalanced by an equal impulse toward specificity. Form, once arisen, clings to its identity. Each species and each individual holds tenaciously to its present nature. Each strives to contain the creative and abolishing maelstrom that pours unseen through the generations. The past vanishes; the present momentarily persists; the future is potential only. In this spacious present of the real, life struggles to maintain every manifestation, every individuality, that exists. In the end, life always fails, but the amorphous hurrying stream is held and diverted into new organic vessels in which form persists, though the form may not*

be that of yesterday. The evolutionists, piercing beneath the show of momentary stability, discovered, hidden in rudimentary organs, the discarded rubbish of the past. They detected the reptile under the lifted feathers of the bird, the lost terrestrial limbs dwindling beneath the blubber of the giant cetaceans. They saw life rushing outward from an unknown center, just as today the astronomer senses the galaxies fleeing into the infinity of darkness. As the spinning galactic clouds hurl stars and worlds across the night, so life, equally impelled by the centrifugal powers lurking in the germ cell, scatters the splintered radiance of consciousness and sends it prowling and contending through the thickets of the world. . . . Man is himself, like the universe he inhabits, like the demoniacal stirrings of the ooze from which he sprang, a tale of desolations. He walks in his mind from birth to death the long resounding shores of endless disillusionment. Finally, the commitment to life departs or turns to bitterness. But out of such desolation emerges the awesome freedom to choose — to choose beyond the narrowly circumscribed circle that delimits the animal being. In that widening ring of human choice, chaos and order renew their symbolic struggle in the role of titans. They contend for the destiny of a world."

THE UNEXPECTED UNIVERSE
LOREN EISELEY

AGREE WITH HIM, or not, as one may wish, nonetheless the basic premise which Charles Darwin propounded in the nineteenth century stands as one of the seminal observations made by the human mind. It is, simply stated, that the natural world in which we pass our lives, both we of the animal kingdom and the plants which coexist with us, are subject to a set of inflexible rules which say to us that we adapt to the world in which we live, to our environment, or else we perish. That we evolve as circumstances change. It is as Darwin said a process of the "Survival of the Fittest." It seems reasonable to carry that naturalistic thinking into the world of our social existence. Into the world of ideas and thought. Might it be equally true, one might ask, that a social or business structure, a medical organization, lives or ceases to live within the bounds and strictures of a similar group of demands rigidly requiring it to change, to evolve, in an adaptive and pragmatic manner?

These thoughts kept passing through my mind as I traveled home from the recent gathering of our medical organization at Callaway Gardens this past May. A most pleasant environment for such a meeting this place is. One can find any variety of activities, sporting or otherwise, to pass away the time when boredom sets in. Flowers, gardens, boats — even butterfly houses are there to amuse and idle one.

"Darwin might suggest that just as the prickly pear cactus, petrel, finch, and tortoise of Galapagos survived by adapting to a particular environment, so must a social and political organism such as ours confirm to the dictum of adaptability and change."

Concentration upon the task at hand becomes at times difficult under such circumstances. Sidney Lanier knew that as he attempted meaningful work near the Georgia coastal "Marshes of Glynn." But we were there for business. Appointed, chosen perhaps, some of us, to conduct the affairs, to chart the course, of the Medical Association of Georgia for the coming year. You will find the printed account of our labors in this issue of the *Journal.* The deliberations are all there, both the discussions and the decisions which they led to. Both the meaningful and the less meaningful, for there was a bit of each. Read them, or scan, as you like, for they tell of the posture which will be taken by organized medicine in our state during the months ahead. They tell of the people whom you have chosen to represent you and to present that posture.

"They come to us with minds unfettered by rigid preconceptions and with energy and determination not yet blunted by past encounters. . . . The Dinosaurs, we were there, but amongst us were the new species. The adaptive and the evolving."

We talked of many things at Callaway Gardens. Of the delivery of health care — of its availability and its costs and of one's access to it. Of politics and politicians, both local and national. Of disease and of its biologic and social and financial impact upon our lives. Of abortion and our varied views of this inflammatory matter as those views existed in the garden of our thinking and as nurtured by our individual cultural environments. We talked of our children in the world we envision to be best for them. We talked, discussed, we debated both early and late until the beckoning of golf and tennis and butterfly seduced and lured us away.

And so it was that I found myself in thought as we traveled away from this garden spot. I found in my reverie no answers but only questions. It is Socratic you see. I am no Socrates, yet early I was taught that any fool can ask questions and that on occasion they are answered. Had we then, I mused, addressed those issues most in need of an answer? Had we truly looked into those troubling areas of our lives where divergent views assured uncomfortable solutions? Had our attention been focused on issues having no bearing on our personal lives or had we been obsessed with our own welfare? Perhaps most persistent was the recurring and aggravating, the vexing, concern posed by the wonder of whether, or not, we as an organization were conducting ourselves in such a manner as to be one of the fittest. How would we stack up as one of those destined by characteristics of tenacity and adaptability to survive. No room in this world of change and conflict for the inflexible and unpragmatic I thought. No room either for the crass, the inconsiderate, and the insensitive. Are we truly an evolving and adaptive organization, I asked myself? Are we ready for the uncertain future? And then I thought of Joy Maxey and Bill Jones and Cathy Anderson and one hundred other young physicians who sat there with us in the Gardens. These were the ones upon whom our future would rest. They come to us with minds unfettered by rigid preconceptions and with energy and determination not yet blunted by past encounters. I was at ease. The Dinosaurs, we were there, but amongst us were the new species. The adaptive and the evolving.

The Galapagos Islands lie 600 miles to the West of Ecuador, a Province of that country yet isolated from it. Charles Darwin spent 5 weeks there in 1835 when the *H.M.S. Beagle,* an English research and exploring vessel, landed there. He soon became aware of the unique characteristics of the flora and fauna present on the several volcanic islands in the Galapagos group. They had evolved, adapted, and thus survived and yet in a manner different from their cousins on the distant mainland. Darwin might suggest that just as the prickly pear cactus, petrel, finch, and tortoise of Galapagos survived by adapting to a particular environment, so must a social and political organism such as ours conform to the dictum of adaptability and change. The gentle winds of change, or perhaps the tornado, blew through the meeting in one way as the new president proposed a careful look, an evaluation, of our structure, our goals, and the efficiency of our functioning. Hope resides here when hard questions are asked and difficult answers pursued. Will we recognize ourselves, our organizations, in the year 2000? We can only hope that such recognition will be difficult.

CRU

CANDLE IN THE WIND

Like a thought tingling the consciousness
To keep alive, a candle braves the wind
With flame that flickers through the tempest blasts
To keep aglow some little bit of light,
Then finds its final bleak futility
As dawn's first rays spill over the eastern rim
To drown the flame with day's first cup of sun. —
But someone saw it shining from afar
And lived because each night must have one star!

ENTENDUE

Set your flowers straight,
Look well to place your ruffles in their proper
Careless and haphazard way,
Let your flowing curls lie limp
Across the pallor
Of your cheek this day.
The briefest moment of our triumph
Beckons now.
Are those footsteps on the stones?
How hollow and how lonely
Is their sound — a sound of solitude!
But lovers (even happy ones)
Must learn to feast
On solitude.
Your shoe strap seems a bit askew.
Perhaps it should
For proper composition.
There is a growing reddish stain
Upon my shoe —
So much for that —
The sounds are drawing close!
The time is here! Please, no regrets!
My dear, the Montagues have come —
What can have kept the Capulets?

JOHN RANSOM LEWIS, M.D.

Dr. Lewis, a plastic surgeon in Atlanta, is Georgia's Poet Laureate.

Array of Proposed Medicare Cuts Presages Health Care Crisis

Editor's note: The following remarks are adapted from congressional testimony presented to the Senate Finance Committee by Carol M. McCarthy, president of the American Hospital Association.

The president's proposed spending level for Medicare in FY 1991 is an example of a short-term budgetary expedient with long-range untoward consequences.

Funds to support Medicare are drawn from a trust fund set up to ensure that the government delivers on its promises. Unfortunately, for the past seven years, trust has been in short supply as the dedicated funds have gone to mask the size of the federal deficit and to offset federal budget shortfalls.

This practice must stop. If Congress follows the president's lead and adds the proposed cuts to the $18 billion already removed since the onset of PPS, those who suffer will no only be Medicare beneficiaries but all of us who depend on hospital care in time of sickness and injury.

The facts are disturbing. Without any cutbacks in projected outlays for FY 1991, the average hospital's Medicare margin will be between negative 8 percent and negative 11 percent. More than 70 percent of all hospitals will suffer losses treating Medicare beneficiaries. For one-half of them, the deficit will exceed 10 percent. For one out of every four, it will top 25 percent.

Enact the president's proposed cuts — reduce Medicare payments to hospitals by another 6 percent — and today's severe financial pressure becomes tomorrow's crisis.

Already the cost shift to private payers for underpayments by Medicare and Medicaid stands at 10 percent. When coupled with uncompensated care shortfalls, our private payers are experiencing an average 20 percent add-on to their bill. This threatens the very viability of our private insurance system.

The hospital field cannot sustain the proposed cutbacks simply by becoming more efficient. Efficient operations already are the rule.

The president calls for a FY 1991 price update of 4.1 percent when the government itself estimates hospital marketbasket inflation at 5.4 percent and when the increase in the Medicare population alone will occasion a 1.7 percent increase in Medicare outlays.

But the administration doesn't stop there. It calls for a 10 percent cut in outpatient payment when the Prospective Payment Assessment Commission estimates that hospitals already lose 19 percent under ambulatory-surgery rates. A 10 percent cut in payments for outpatient care will fall particularly hard on rural hospitals. In their efforts to reconfigure, rural hospitals have shifted a high proportion of care to the outpatient setting.

The administration also would maintain the 15 percent cut in capital payments to rural hospitals and increase that cut to 25 percent for all other facilities.

This proposal not only ignores the reality of past obligations that are not subject to modification, it turns all capital acquisitions driven by patient care considerations into losing propositions and erodes hospitals' creditworthiness.

Finally, the administration would slash payment to teaching hospitals for direct and indirect medical education. The cuts would go so deep that, combined with a proposed reduction in the PPS update factor, the average teaching hospital could look forward to a PPS margin of negative 13 percent to negative 16 percent — a loss of more than $300 per Medicare patient.

It's time for Congress to say a resounding "no" to such unsound public policy proposals. It is time to repair the damage of years of budget-driven cutbacks. It is not time to make a bad situation worse.

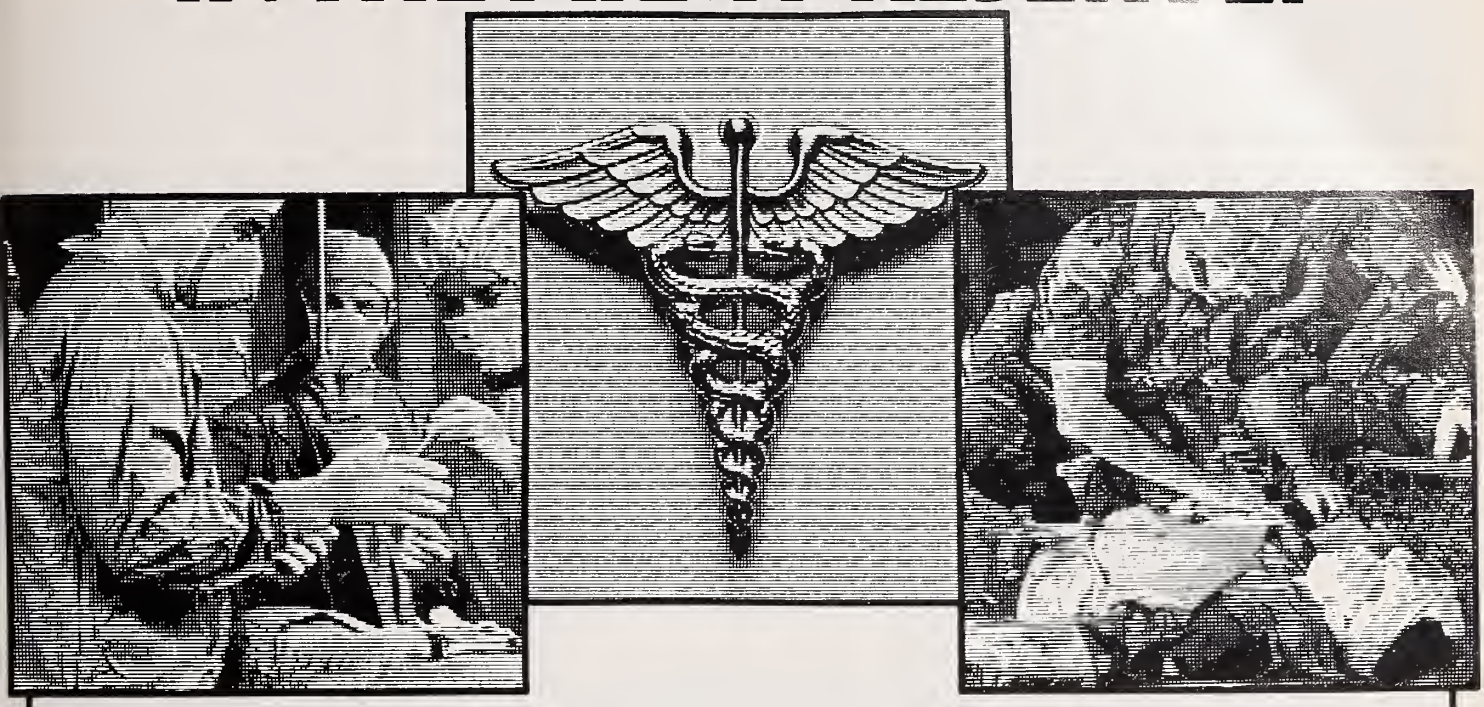
JCAHO Panel Approves New Standards Proposals

Under standards proposed by a committee of the Joint Commission on Accreditation of Healthcare Organizations, hospitals would be required to develop plans for effective communication with patients who speak the predominant language of their communities.

"If hospitals have a non-English speaking population or treat hearing-impaired patients, we want them to be able to communicate with [those patients]," said Pam Shumacher, a spokeswoman for the Chicago-based commission.

Recommended by the commission's Standards and Survey Procedures Committee, both proposed standards are expected to be voted on by the organization's board.

GENERAL SURGERY TAKES ON NEW MEANING IN THE ARMY RESERVE.



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First General Session

Summary of the Proceedings

136th House of Delegates

April 26, 1990

James A. Kaufmann, M.D., Speaker of the House.

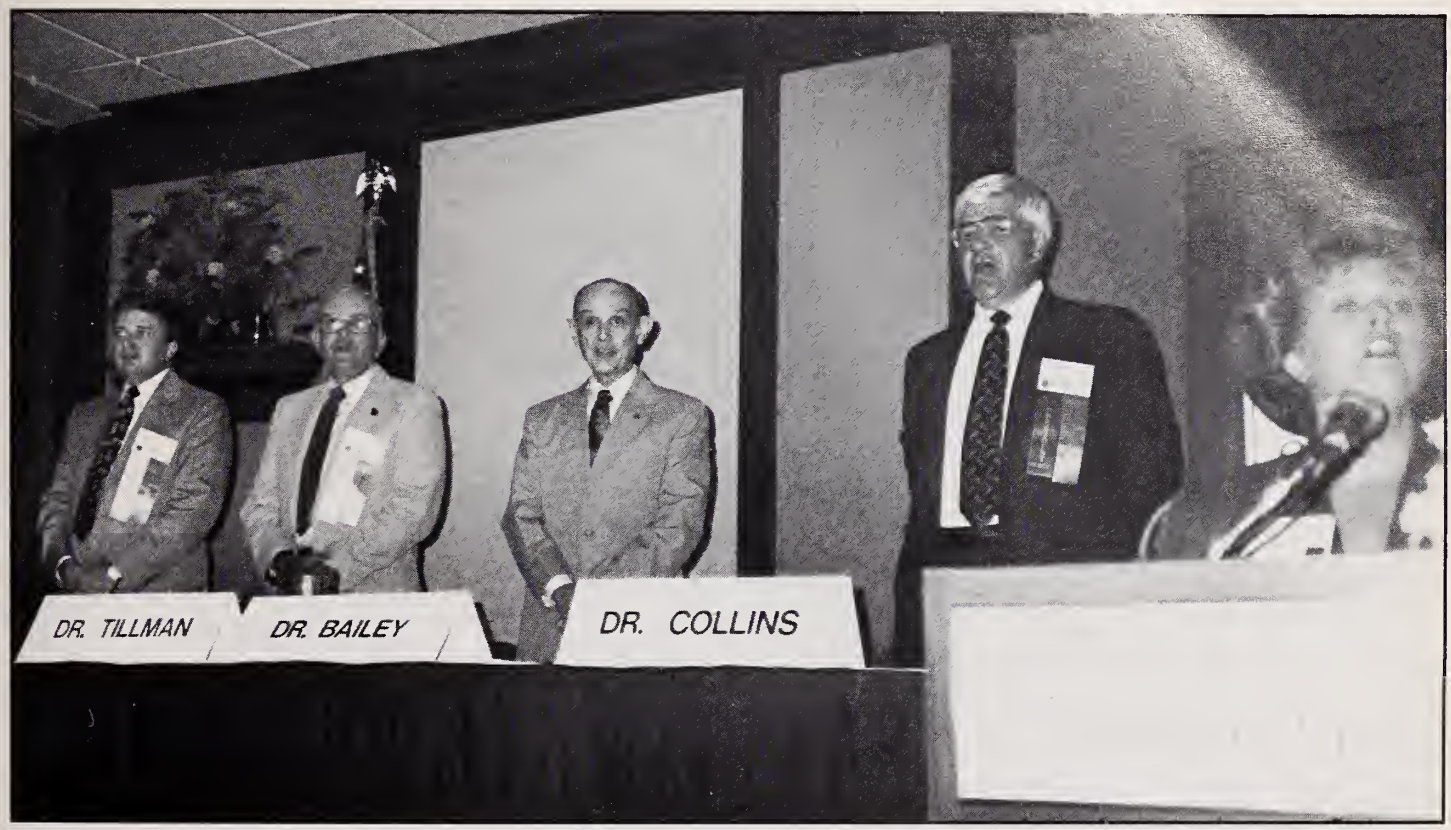
Call to Order

THE FIRST general session of the 136th Annual session of the Medical Association of Georgia was called to order by President Joe L. Nettles, M.D., of Savannah, at 7 p.m., Thursday, April 26, 1990, at Callaway Gardens Inn in Pine Mountain.

The Rev. Gilbert Ramsey of St. Paul's Methodist Church of Columbus delivered the invocation. Jana Hill sang the National Anthem, accompanied by Glenda Bates on the piano. Dr. Nettles led the group in the Pledge of Allegiance.

Dr. Nettles welcomed all those attending the 1990 Annual Session and introduced Larry Brightwell, M.D., president of the Muscogee County Medical Society, the host for this year's annual session.

Dr. Brightwell welcomed the audience to Callaway Gardens.



Singing along with Jana Hill, the 1989-90 Auxiliary President-Elect, during the opening ceremonies of the House of Delegates are (L to R): Drs. Bob Lanier, incoming Treasurer; Ralph Tillman, outgoing Secretary; Joe Bailey, Immediate Past President; and Bill Collins, President-Elect.

Memorial Service

Dr. Nettles asked the audience to stand in memory of those members who died during the past year and observe a moment of silence. They are: Herbert S. Alden, M.D., Lane H. Allen, M.D., C. R. Barksdale, Jr., M.D., H. Bagley Benson, M.D., Ashok Bhoomker, M.D., A. Frederick Bloodworth, M.D., R. A. Burns, M.D., Morris Brackett, M.D., James B. Craig, M.D., Thomas A. Cochran, M.D., R. E. Dallas, M.D., Albert M. Deal, M.D., Edward S. Forrester, M.D., W. Elizabeth Gambrell, M.D., C. Steadman Glisson, M.D., William E. Gray, M.D., Joseph C. Hatch, M.D., Arthur M. Hendrix, M.D., Byron J. Hoffman, M.D., Lynn M. Huie, M.D., John J. Hyers, M.D., James B. Kay, Jr., M.D., William P. Leonard, M.D., William H. Lucas, M.D., Lewis McDonald, M.D., John M. McGehee, M.D., Arthur J. Merrill, M.D., Otis C. Mitchell, M.D., William H. Moretz, Sr., M.D., E. Mansell Pattison, M.D., Pablo Piedrahita, M.D., Samuel R. Poliakoff, M.D., Ronald B. Prince, M.D., John R. Rinker, M.D., John J. Skinner, Jr., M.D., Carter Smith, Sr., M.D., Charles F. Stone, Jr., M.D., Morris Taranto, M.D., Warren Terrell, M.D., John W. Thompson, M.D., H. A. Thornton, M.D., John R. Wakefield, M.D., Robert J. Walker, Jr., M.D., Eugene L. Ward, M.D., W. Dean Warren, M.D., James P. Watson, M.D., and Theodore C. Whitson, M.D.

Fifty-Year Members

Those members who have practiced medicine for 50 years or more were then recognized. They include: John T. Akin, Jr., M.D., W. H. Bedingfield, M.D., H. William Bondurant, M.D., Stephen W. Brown, M.D., Sandy B. Carter, M.D., P. D. Conger, M.D., Cordelia K. Downman, M.D., W. P. Downey, M.D., Asa D. Duggan, M.D., R. W. Edenfield, M.D., W. Stewart Flanagin, M.D., Regin Gabler, M.D., W. R. Garner, M.D., Katrine Rawls Hawkins, M.D., Hartwell Joiner, M.D., Daniel E. Nathan, M.D., R. H. Randolph, M.D., E. A. Roper, M.D., Ben R. Thebaut, M.D., Herbert D. Tyler, M.D., C. W. Whitworth, M.D., and R. K. Winston, M.D.

Life Members

Life members are those physicians who have supported organized medicine for at least 25 years, and are at least 70 years old. They too were recognized as follows: Alfred Agrin, M.D., W. H. Benson, M.D., Henry H. Boyter, M.D., Augustus W. Bramblett, Jr., M.D., Dan Burge, M.D., Rives Chalmers, M.D.,

M. Bedford Davis, Jr., M.D., Thomas E. Dupree, M.D., Reese C. Eberhardt, M.D., R. A. Elmer, M.D., Richard E. Felder, M.D., Milton H. Freedman, M.D., Harold W. Goldin, M.D., H. A. Goodwin, Jr., M.D., A. V. Gude, M.D., Billy S. Hardman, M.D., Frank Hardeman, Jr., M.D., Henry D. Holliman, M.D., Charles R. Ireland, M.D., Joseph M. Jackson, M.D., Alfred Joseph, M.D., W. W. Kanter, M.D., Joseph L. Kurtz, M.D., George C. Lawrence, M.D., William Earl Lewis, M.D., J. D. Martin, Jr., M.D., Marcus Mashburn, Jr., M.D., B. A. McCrum, M.D., W. C. McCarber, Jr., M.D., Fenwick T. Nichols, Jr., M.D., William L. Paullin, Jr., M.D., William J. Pendergrast, M.D., Quentin Pirkle, Sr., M.D., Robert N. Poole, M.D., Carol G. Pryor, M.D., John H. Reed, Jr., M.D., Walter J. Revell, M.D., John E. Skandalakis, M.D., R. L. Smith, Sr., M.D., Edward Roe Stamps, M.D., H. Haywood Turner, M.D., Jack M. Waldrep, M.D., Edgar Woody, Jr., M.D., and Robert J. Zimmerman, M.D.

Certificates of Appreciation

Certificates of Appreciation are given to those members and others who have been active in Association affairs and through their talents and hard work have made special contributions to the Medical Association of Georgia.

The following individuals were awarded certificates: Joe L. Nettles, M.D., president of MAG, 1989-1990; Cyler Garner, M.D., Treasurer of MAG, 1989-1990; Mrs. Charles Walden, 1989-1990 president of the Auxiliary to the Medical Association of Georgia; F. William Dowda, M.D., for his services as a dedicated member of MAG's AMA Delegation from 1986 to 1990; Bob G. Lanier, M.D., for his term as 1989-1990 First Vice President; Roy W. Vandiver, M.D., for his term as Second Vice President; Richard Cohen, M.D., for his service from 1985 to 1990 as an Alternative Director; Charles McDowell, M.D., for his years of dedicated service from 1987 to 1990 as a MAG Director; Joy A. Maxey, M.D., for her outstanding service as Chairman of the Young Physician Section, 1989-90; Phillip K. Rhyne, for his leadership as Chairman of the Medical Student Section, 1989-90; Joseph P. Bailey, Jr., M.D., for his service as Chairman of the Council on Education from 1984 to 1989 and as a crusader for Medicare justice from 1989 to 1990; William Waters, III, M.D., for his years of service to MAG, first as an Alternate Director from 1976 to 1989 and as a Director from 1989 to 1990; Ralph A. Tillman, M.D., for his term as MAG Secretary from 1984 to 1990; Maurice G. Patton, M.D., for his work as District Public Health Officer from 1972-90; Cheri Dennis for her term as Auxiliary Legislative Committee Chairman, 1989-90; Carolyn Moon for her term as Chairman of the Auxiliary Legislative Phone Bank, 1989-90; Barbara Thibodeaux for her term as Southern Medical Association Auxiliary President, 1988-89; Judy Domescik of the Auxiliary for her term as AMA-ERF Chairman, 1989-90; Sandra Burns for her term as Auxiliary Chairman of Health Projects, 1989-90; Nancy McCord for her work resulting in an Auxiliary membership increase, 1989-90; Tom Anderson, M.D., for his term as Chairman of the Board of Directors, 1989-90; Emory C. Bohler, M.D., for his term as Chairman of MAG's Judicial Council, 1983-89; Ralph A. Murphy, Jr., M.D., for exemplary service with the Georgia Medical Care Foundation; Peter Lampros, M.D., for his term as Third Party Payor Committee Chairman, 1985 to 1989; Julian Duttera, M.D., for his term as Chairman of MAG's Committee on Access to Medical Care; and LaMar McGinnis, M.D., for his term as Chairman of MAG's Committee on Cancer, 1985-1990.

Dr. Nettles also recognized two individuals who have been outstanding friends of medicine, Senator Ted Land of Columbus and Rep. Roy Moultrie of Hamilton. Presenting certificates of appreciation awards to both was Dr. John Watson of Columbus.

Recognition of Guests

Dr. Nettles recognized Dr. and Mrs. John Thomson of Tennessee and Dr. and Mrs.T. Reginald Harris of North Carolina, who were visiting the annual meeting.

Introduction of the President-Elect

Dr. Nettles introduced William C. Collins, M.D., of Atlanta, 1990-1991 President-Elect of MAG.

Report of the Auxiliary

Mrs. Charles Walden gave the report on the activities of the 1989-1990 Auxiliary of the Medical Association of Georgia. Her year's theme, "Proud to Be Auxilians," was carried throughout her message to the House of Delegates. She concluded her message with a poem she wrote telling of the honor she has felt and shares with other Auxilians as they work for better medical care in Georgia and the nation.

AMA-ERF Checks

Each year the American Medical Association-Education Research Foundation distributes to medical schools funds from contributions mainly from the medical family that are collected in large part by the Auxiliary to the American Medical Association and its various organizations.

Mrs. Judy Domescik and Mrs. Grace Walden assisted Dr. Nettles in presenting the money raised for the four medical schools: the Medical College of Georgia, Emory University School of Medicine, Morehouse School of Medicine and Mercer University School of Medicine.

Awards

Hardman Cup

This award is presented for the achievement of anyone who in the judgment of the Association has solved any outstanding problems in public health or made any discovery in medicine or surgery or such contribution to the science of medicine. It is not given annually, but only when a candidate merits this special honor. In the 40 years since it was first presented, it has been given only 21 times. This award was first given in 1949 to Dr. John Elliott of Savannah.

The 1990 recipient of the Hardman Cup is also from Savannah, Dr. Mason G. Robertson. Dr. Nettles said, "The presentation is a special privilege for me, because I have known Dr. Robertson for more than 20 years. When I first knew him, his progressive ideas made some think of him as a radical. Today, we in Savannah's medical community reap the rewards of his foresight."

Dr. Robertson helped develop a house staff training program at the Memorial Medical Center that is today an outstanding program. He served as chairman of the Chatham-Savannah Health Council, which was concerned with fluoridation of the water, support for the care of sickle cell patients, health and hospital planning, care of indigent patients, and regional health planning. He served on the Council for more than 20 years and shared in the establishment at the Memorial Medical Center of a specialized clinic for sickle cell patients. He initiated with the Nursing Department of the Memorial Medical Center a self-care training program for hemophiliacs.

Dr. Robertson's first experience in public service was in the 1950s, when, while still in training at Emory University School of Medicine, he helped give hundreds of Salk vaccine inoculations to the school children of DeKalb County. The year before he had worked on the special ward for polio victims at Emory University Hospital, and when in 1955, the Salk vaccine made this ward obsolete, he became convinced of the importance of public health medicine.

Dr. G. Mason Robertson, of Savannah, (L) is this year's honored recipient of MAG's coveted Hardman Cup award, presented here by President Joe Nettles. Dr. Robertson has contributed tremendously to public health medicine in Savannah.

Largely due to his efforts for indigent patients, Savannah has attracted and today enjoys excellent facilities for the treatment of cancer patients.

At his instigation, the first family practice training program in Savannah was begun at Memorial Medical Center.

Dr. Robertson has been a giant in Savannah's community, speaking often for those who had no other voice. It is with great pleasure that we give the 1990 Hardman Cup to Dr. Mason G. Robertson.

Civic Endeavor Award

The second of MAG's awards is unique among all of the awards given by the MAG. It is named "Civic Endeavor," and its purpose is to honor those physicians whose motivations find their essential expression in doing good deeds for the public through participation in civic affairs.

The recipient of the Civic Endeavor Award this year is Dr. Luther E. Brown, an ophthalmologist from Macon. Dr. Brown was killed two years ago in an accident while in

Europe, and he is sorely missed in Macon.

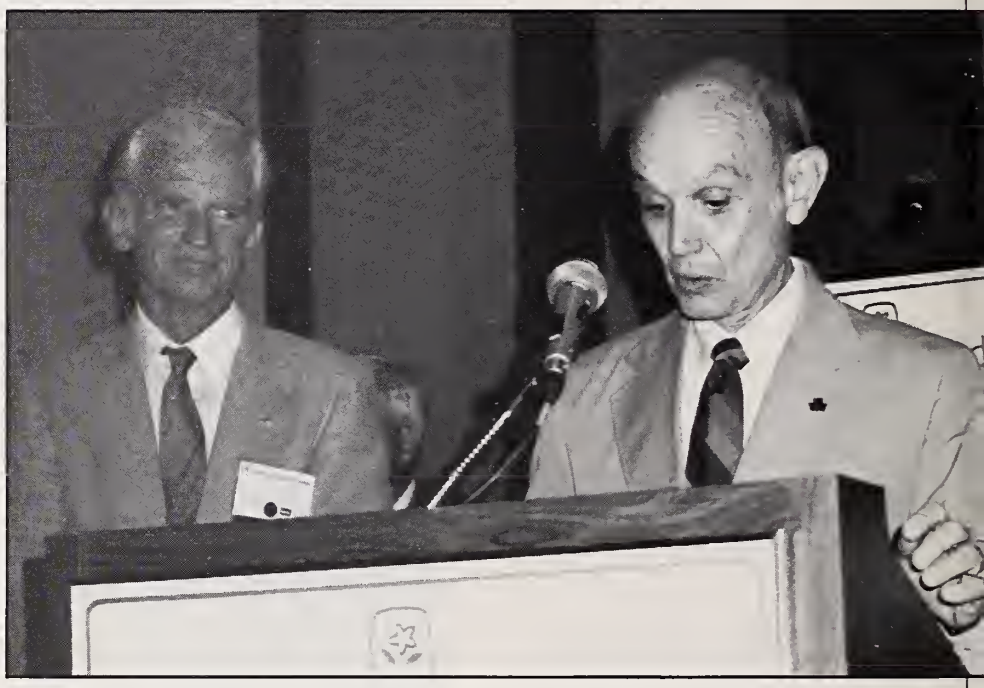
Following an ophthalmology residency at Walter Reed Army Hospital in Washington, Dr. Brown set up practice in Macon where he began a long career of community service. He was president several times of both the Bibb County Medical Society and the Georgia Society of Ophthalmology. He excelled as a civic leader, serving in many capacities in the community. Among these were his leadership on the administrative board of the Vineville United Methodist Church, the Downtown Council and the Macon Arts Alliance. He played a key role on the boards of the Rotary Club, Intown Macon Neighborhood Association and the United Way.

His dedication to youth was shown by serving as assistant scoutmaster, seventh grade Sunday school teacher, and as the "eye doc" for the Georgia Industrial and Methodist Children's Home. He was serving in 1988 as Vice-Chairman of the Greater Macon Chamber of Commerce Executive Committee and as a Board Director of the Macon Symphony Orchestra.

Dr. Brown was indeed a physician's physician. He was instrumental in establishing a private ambulatory surgery eye care center whose facility was the first of its kind in Georgia. Above all, he was a gentleman whose concerns and caring for his hometown were reflected by his civic and community leadership roles.

It is said that the measure of a tree can only be made when it is felled. Sadly, this is also true of men. His work in his profession, for his church and his community was cut short, but in that relatively short time, he made a significant difference in the lives of so many.

Accepting the award on behalf of her late husband, was Nancy Brown.



Dr. Joseph P. Bailey, Jr., (R), MAG's Immediate Past President, was one of two recipients of the Distinguished Service Award. Dr. Bailey was honored for his tireless and effective efforts to help solve the legion Medicare problems experienced by Georgia physicians this past year.

Distinguished Service Award

The third awards given were the Distinguished Service Awards. This award is presented for distinguished and meritorious service that reflects credit and honor on the Association. Over the past 29 years, this award has been presented only 23 times.

This year the committee's decision was to give two distinguished service awards to the two most outstanding nominees.

The winners of this year's 1990 Distinguished Service Awards are Dr. Joseph Bailey, Jr., of Augusta, and Dr. Edwin Evans, of Atlanta.

Dr. Bailey, who was our Immediate Past President, worked tirelessly and effectively to permit physicians to render the highest quality and dedicated medical care to their patients. During the past year, he led the battle in problems we have all faced with Medicare. He fought that battle with the highest of principles even when attacked. His dedication to the MAG is second to none, but he has also distinguished himself as a dedicated physician, medical educator, and administrator.

Dr. Bailey is the Medical College of Georgia's Charbonnier Professor of Medicine. He was a member of the MAG Board of Directors, he is one of our Alternative Delegates to the AMA and has been a Delegate to the MAG House of Delegates for many years.

Dr. Edwin Evans has served medicine for 42 years, and is a dedicated physician and educator who has also given a great deal of this time and talent to organized medicine.

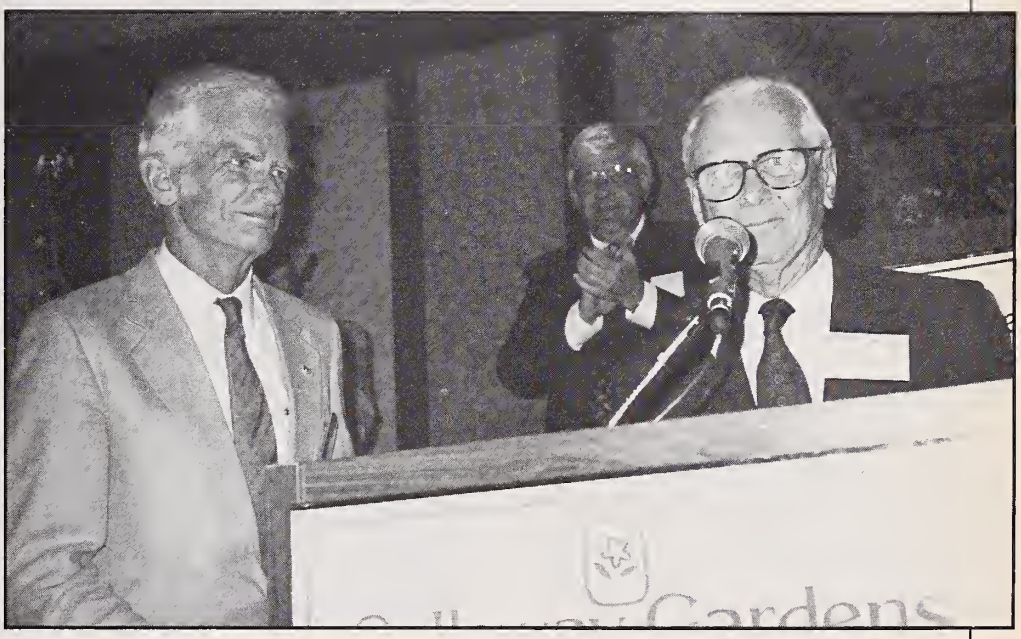
He has served as president of the Medical Association of Atlanta, the Diabetes Association of Atlanta, the Georgia Diabetes Association, the Georgia Society of Internal Medicine, the American Society of Internal Medicine, the Southern Medical Association, and has been a

delegate from MAA to the MAG House of Delegates for more than 27 years.

In addition, he has served as Governor for the Georgia Chapter of the American College of Physicians and on numerous boards and committees of medical organizations from the local to national levels. He has been a part of the teaching faculty at Emory University School of Medicine since 1948.

Family Physician of the Year

Next, MAG recognized the outstanding Georgia Family Physician. The selection of the recipient was made by the Board of Directors of the Georgia Academy of Family Physicians. Presenting the Family Physician of the Year Award for 1990 was Dr. Paul Forney, of Augusta, President of the Georgia Academy of Family Physicians. The recipient of the award was Dr. Dwana Bush, of Atlanta.



Dr. Edwin Evans, an internist from Atlanta, was also a recipient of MAG's Distinguished Service Award. Dr. Evans has served medicine for 42 years through active involvement in several professional organizations from the local to national levels. Shown here with him are (L to R) Drs. Joe Nettles and Bill Collins.

Dr. Dwana Bush, of Atlanta, received the Family Physician of the Year Award which was presented by Dr. Paul Forney (R), of Augusta, President of the Georgia Academy of Family Physicians. Dr. Bush was honored for her commitment to family medicine and community involvement, especially with regard to helping meet some of the medical needs of the homeless.

Dr. Forney made the following remarks as he presented the Award: "As President of the Georgia Academy of Family Physicians, it is my pleasant duty to present the 1990 Family Physician of the Year award. This year's recipient is an outstanding role model in the rigorous task of successfully balancing the demands of a practice, a family, and a commitment to the community.

"She has been in private practice in Atlanta since completing her residency in family medicine at the Medical University of South Carolina in 1983. Since then she has become an active participant in such organizations as the Medical Association of Georgia, the Georgia Academy and the Medical Association of Atlanta.

"She is a clinical assistant professor of medicine at Emory University and, over the years, has become well-known for her published works and lectures on a variety of topics including death and dying and health care for the homeless.

"She doesn't view the often neglected homeless population as just another statistic. They have, indeed, found a true and dedicated friend in this year's recipient. She is the co-founder and volunteer medical director of the Mercy Mobile Health Project which is designed to provide health care to the homeless. In addition, she serves as medical director for the Atlanta Community Health Project for the Homeless.

"She is a strong believer in the future of family medicine and that belief is confirmed by her on-going involvement with medical students. She is an active participant in the Student Member Group at Emory, and has, most recently, gotten the students involved with Atlanta's homeless.

"As a practicing physician, concerned individual and mother of two small children, this year's recipient appears to be a prime example of 'being able to do it all.'

"It is my pleasure to present the 1990 Family Physician of the Year award to Dr. Dwana Bush of Atlanta."

A.H. Robins Award

A. H. Robins makes the award available in the belief that members of the health team should use all appropriate ethical means of improving and enlarging the stature of the physician, as a professional and as a participant in community life. MAG's recipient for the A. H. Robins Award for community service is Dr. O. Wytch Stubbs, Jr., of Decatur.

Dr. Stubbs, a native of Millhaven, Georgia, has received virtually every civic and professional award given in the Decatur area including the coveted Julius McCurdy Citizenship Award from the Decatur Federal Savings and Loan Association, the DeKalb Bar Association's Liberty Bell Citizenship Award, and the Emory University Alumni Award of Honor.

He has served his profession with distinction as President of the DeKalb Medical Society, President of the Emory University School of Medicine's Alumni Association and the International Alumni Association and Clinical Professor at Emory's Department of Community Health. He served as a high school team physician for 5 years and as medical director of the Scottdale Community Free Clinic for 7 years.

Dr. O. Wytch Stubbs (L), of Decatur, is presented with the A.H. Robins Award by President Joe Nettles. Dr. Stubbs was honored for his years of service to both the medical profession and his community.

Charles R. Drew Award

The final award was the Charles R. Drew Award presented by the Medical Student Section. This was the first year this award has been presented. The Drew Award is given to an individual who has performed an outstanding service to the medical student section. David Arnett, Vice Chairman of the Medical Student Section, presented the award to Ms. Frances Friedman of Augusta, who works with programs that help children with cancer, including a summer program called Camp Rainbow. Ms. Friedman raises the money and trains the volunteers for the outstanding programs she provides for the children.

Announcements

Before ending the First General Session, Dr. Nettles directed several items of interest to the audience's attention:

1. The House of Delegates was to convene immediately at the conclusion of the General Session. The House was scheduled to recess at approximately 10 p.m. Reference committees would begin at 9 a.m. on Friday.

2. GAMPAC would sponsor a breakfast for us in the morning at 7:30 a.m. in this room, with guest speaker Kim Ross from the Texas Medical Association.

3. MAG Mutual would sponsor an open forum luncheon tomorrow at 12:30 p.m. in the Magnolia Room.

4. At 7 p.m. Saturday, there was to be the MAG and Auxiliary Presidents' Reception.

This concluded the business of the First General Session. The First Session of the House of Delegates started approximately 5 minutes later.

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Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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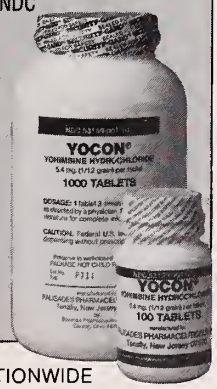
References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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First Session
House of Delegates
April 26

THE FIRST SESSION of the MAG House of Delegates was called to order by Speaker of the House James A. Kaufmann, M.D., at 8 p.m., Thursday, April 26, at Callaway Gardens in Pine Mountain. Jack A. Raines, M.D., of Columbus, served as Vice Speaker of the House. The Speaker then enjoined the delegates with the following remarks:

"The Constitution directs that the House of Delegates is the legislative body of the Association and it shall transact all business of the Association. The decisions you make over the next 3 days will become the policy of the Association, and they will determine the course of action that our Association will follow for the coming year. I urge you to appreciate the full weight of this responsibility. As members of this legislative body, each of you represents not only the physician members of your respective county medical societies, but in fact, represents physicians in all parts of the state."

Report of the Credentials Committee

The Speaker called for a report from the Credentials Committee which was given by Larry Brightwell, M.D. Dr. Brightwell reported that 405 delegates and alternate delegates representing 37 component county medical societies were attending and accordingly announced that a quorum of the House of Delegates was present.

Delegate and Alternate Delegate Attendance

The following physicians served as Delegates to the House: Donald C. Abele, M.D., William E. Adams, M.D., David C. Allen, M.D., Joseph M. Almand, Jr., M.D., Robert H. Anderson, Jr., M.D., Thomas J. Anderson, Jr., M.D., Catherine S. Andrews, M.D., John S. Antalis, M.D., Harold Asher, M.D., Phil C. Astin, Jr., M.D., Joseph P. Bailey, Jr., M.D., Phillip N. Bannister, M.D., William E. Barfield, Sr., M.D., J. Dan Bateman, M.D., James F. Beattie, Jr., M.D., William H. Biggers, M.D., H. Duane Blair, M.D., David C. Bosshardt, M.D., Gary Botstein, M.D., Rupert H. Bramblett, M.D., Donald L. Branyon, Jr., M.D., Spencer S. Brewer, Jr., M.D., Larry Brightwell, M.D., William P. Brooks, M.D., William S. Brooks, III, M.D., Paul C. Broun, Jr., M.D., Algie C. Brown, M.D., Gwynne T. Brunt, Jr., M.D., Robert Buckley, M.D., Carson B. Burgstiner, M.D., Billy D. Burk, M.D., Robert A. Burns, M.D., William B. Burns, Jr., M.D., Charles C. Burton, M.D., Leon H. Bush, M.D., Donald H. Campbell, M.D., Frank E. Carlton, M.D., Albert A. Carr, M.D., Robert Glenn Carter, M.D., Marsha J. Certain, M.D., Joseph Citron, M.D., Thomas S. Claiborne, Jr., M.D., Elizabeth M. Clark, M.D., S. William Clark, Jr., M.D., Spurgeon William Clark, III, M.D., Teresa E. Clark, M.D., Michael J. Cohen, M.D., Richard W. Cohen, M.D., Chappell A. Collins, Jr., M.D., William C. Collins, M.D., Don R. Connell, M.D., Anthony M. Costrini, M.D., L. T. Crimmins, M.D., David E. Dalrymple, M.D., Robert L. Davies, M.D., Alfred L. Davis, Jr., M.D., Dave M. Davis, M.D., H. G. Davis, Jr., M.D., R. Carter Davis, Jr., M.D., William

Delegates attending MAG's 136th House of Delegates include Drs. Bill Headley (standing), Charles Lanford, Alex Weaver, Milton Johnson, Jack Menendez, and Alva Mayes.

S. Davis, M.D., Abelardo R. Delgado, M.D., Ervin D. Deloach, M.D., Paul L. Dickson, M.D., William L. Dobes, Jr., M.D., Harry N. Dorsey, M.D., F. William Dowda, M.D., M. Julian Duttera, Jr., M.D., Mark J. Eanes, M.D., J. W. Estes, M.D., Daniel M. Feldmn, M.D., Stanley M. Fineman, M.D., Sumner Fishbein, M.D., Gilbert J. Foster, Jr., M.D., John Ed Fowler, M.D., David J. Frolich, M.D., Stefan H. Fromm, M.D., Cyler D. Garner, M.D., Doy O. Gay, II, M.D., John A. Goldman, M.D., Ken Goldman, M.D., Robert D. Gongaware, M.D., Thomas L. Haltom, M.D., O. Emerson Ham, Jr., M.D., Carl V. Hancock, Jr., M.D., Buford G. Harbin, M.D., William R. Hardcastle, M.D., J. Harold Harrison, M.D., J. Rhodes Haverty, M.D., William H. Hayes, M.D., Ralph L. Haynes, M.D., William McKendree Headley, M.D., William C. Heard, M.D., Irvin D. Hellenga, M.D., Peter L. Henderson, Jr., M.D., E. V. Herrin, M.D., Robert S. Hill, M.D., William E. Holladay, Jr., M.D., Emory W. Holloway, Jr., M.D., Hamilton E. Holmes, M.D., George B. Hubbard, Jr., M.D., Mark C. Hutto, M.D., Philip Z. Israel, M.D., Eugene H. Jackson, M.D., Kenneth S. Jago, M.D., Jane B. Jennings, M.D., Joel M. Johnson, III, M.D., Milton I. Johnson, Jr., M.D., J. Richard Jones, M.D., William B. Jones, M.D., James A. Kaufmann, M.D., Ellis B. Keener, M.D., J. W. Kelley, M.D., P. Rao Kondur, M.D., W. K. Lane, M.D., Charles A. Lanford, M.D., Bob G. Lanier, M.D., Willis E. Lanier, M.D., Leslie S. Leighton, M.D., Jack L. Lesher, Jr., M.D., Walter M. Ligon, M.D., Charles Gary Lodge, M.D., William D. Logan, Jr., M.D., Gary R. Loveless, M.D., Mary C. Lucchese, M.D., Michael J. Maloney, M.D., Donald H. Manning, M.D., Joy A. Maxey, M.D., William E. May, M.D., Alva Louie Mayes, Jr., M.D., J. Daniel McAvoy, M.D., Harry C. McDonald, M.D., Charles McDowell, M.D., Jack F. Menendez, M.D., Margaret Mermin, M.D., Cecil L. Miller, M.D., Frank R. Miller, M.D., George D. Miller, M.D., William C. Miller, Jr., M.D., Edmund M. Molnar, M.D., W. W. Moore, Jr., M.D., Martin J. Moran, M.D., Rene A. Morell, M.D., Hugo S. Moreno, M.D., Joseph V. Morrison, Jr., M.D., Gerald B. Muller, M.D., A. Delone Muse, Jr., M.D., Ellis H. Nelson, M.D., Joe L. Nettles, M.D., Bruce C. Newsom, M.D., Jeffrey T. Nugent, M.D., James L. O'Quinn, M.D., Carol H. Oster, M.D., Clarence M. Paine, Jr., M.D., Robert M. Patton, M.D., Alan Plummer, M.D., Thomas E. Price, M.D., Dent W. Purcell, M.D., Willard E. Quillian, III, M.D., Jack A. Raines, M.D., Walker L. Ray, M.D., Michael H. Roberts, M.D., Harrison L. Rogers, Jr., M.D., Jim Lee Rogers, M.D., Embra A. Roper, M.D., Ronald P. Roper, M.D., John R. Salazar, M.D., Gerald E. Sanders, M.D., Paul J. Scheinberg, M.D., J. K. Schellack, M.D., John R. Simpson, M.D., Edward H. Smith, Jr., M.D., Rodney L. Smith, M.D., Irvin T. Staley, M.D., Cassius Stanley, M.D., Dan B. Stephens, M.D., Joe C. Stubbs, M.D., O. Wytch Stubbs, Jr., M.D., James H. Sullivan, M.D., Roland S. Summers, M.D., James M. Tallman, M.D., David D. Tanner, M.D., Luther M. Thomas, Jr., M.D., Hugh S. Thompson, Jr., M.D., Lavon Thurman, M.D., William C. Tippins, M.D., James H. Tison, M.D., Charles E. Todd, Jr., M.D., Joel D. Todino, M.D., Fred A. Trest, M.D., Robert P. Tucker, III, M.D., J. R. Turner, M.D., Roy W. Vandiver, M.D., Minor C.

Vernon, M.D., Angela K. Vick, John D. Watson, Jr., M.D., Alexander H. S. Weaver, M.D., Robert E. Wells, M.D., William Wessinger, M.D., Richard A. Wherry, M.D., J. Q. Whitaker, M.D., William G. Whitaker, III, M.D., Paul A. Whitlock, Jr., M.D., Leslie Wilkes, M.D., Joseph S. Wilson, Sr., M.D., Joseph S. Wilson, Jr., M.D., William A. Wolff, M.D., Betty B. Wray, M.D., Charles H. Wray, M.D., Asa G. Yancey, M.D., and John T. Yauger, M.D.

The following physicians served as Alternate Delegates to the House: Benjamin H. Cheek, M.D., Rajinder Chhokar, M.D., James E. W. Crosse, M.D., Miguel A. Faria, Jr., M.D., David R. Fern, M.D., William C. Flanagan, Jr., M.D., H. R. Foster, M.D., Todd S. Jarrell, M.D., C. E. Johnson, Jr., M.D., Werner A. Linz, M.D., David B. McMicken, M.D., E. Capers Palmer, Jr., M.D., Alan S. Peiken, M.D., Stanley W. Sherman, M.D., John P. Syribeys, M.D., Ralph A. Tillman, M.D., and C. Allen Woods, Jr., M.D.

Adoption of Minutes

The Proceedings of the 1989 meeting of the MAG House of Delegates as published in the July, 1989, issue of the *Journal of the Medical Association of Georgia* were approved.

Nominations of Opposed Elections

Speaker Kaufmann announced that only those candidates with opposition will be listed on the ballot for the Saturday, April 28, election. He called on the House to proceed with nominations for open offices.

Treasurer: Roland S. Summers, M.D., of Savannah, was nominated for Treasurer by Emory Bohler, M.D. of Brooklet, and seconded by Jack Menendez, M.D., of Macon, and Alan Plummer, M.D., of Atlanta.

William Jones, M.D., of Gainesville, was nominated by Rodney Smith, M.D., of Gainesville, and seconded by William S. Clark, III, M.D., of Valdosta, Joseph P. Bailey, M.D., of Augusta, and Gwynne Brunt, M.D., of Atlanta.

Election of Unopposed Candidates

It was agreed at the outset that unopposed candidates would be elected at this Session and the names of the candidates who have opposition would appear on the ballot for election, Saturday, April 28. Upon nominations duly made and seconded as indicated below, the following slate of unopposed officers was elected by acclamation:

President-Elect: Cyler D. Garner, M.D., of Gordon, was nominated by Joseph P. Bailey, M.D., of Augusta, and Alva L. Mayes, Jr., M.D., of Macon.

First Vice-President: Roy Vandiver, M.D., of Decatur, automatically steps up from Second Vice President to First Vice President, so no nomination or election is needed.

Second Vice-President: Alva L. Mayes, M.D. of Macon, was nominated by Charles Lanford, M.D., of Macon.

Treasurer: Bob Lanier, M.D. of Cumming, was nominated by Jeffrey Nugent, M.D., of Atlanta, and seconded by Gwynne Brunt, M.D., of Atlanta.

AMA Delegate: S. William Clark, Jr., M.D., of Waycross, was nominated by S. William Clark, III, M.D., of Waycross.

AMA Delegate: Joe C. Stubbs, M.D., of Valdosta was nominated by Ed "Mac" Molner, M.D., of Columbus.

AMA Delegate: Carson B. Burgstiner, M.D., of Savannah, was nominated by Robert D. Gongaware, M.D., of Savannah.

AMA Delegate: William D. Logan, Jr., M.D., of Atlanta was nominated by Jeffrey Nugent, M.D., of Atlanta.

AMA Alternate Delegate: Ed "Mac" Molner, M.D., of Columbus, was nominated by Larry Brightwell, M.D., of Columbus.

AMA Alternate Delegate: Ralph Tillman, M.D., of Lawrenceville, was nominated by Joseph P. Bailey, Jr., M.D., of Augusta.

AMA Alternate Delegate: Ellis Keener, M.D., of Gainesville, was nominated by Robert Anderson, M.D., also of Gainesville.

AMA Alternate Delegate: Joe L. Nettles, M.D., of Savannah, was nominated by Robert D. Gongaware, M.D., also of Savannah.

AMA Alternate Delegate: William C. Collins, M.D., of Atlanta, was nominated by Joseph P. Bailey, M.D., of Augusta.

Director and Alternate Director Elections

The Speaker announced the result of elections for Directors and Alternate Directors, as conducted by the District Medical Societies and County Medical Societies, with terms to expire in 1993:

Seventh District Medical Society

William Lumpkin, Jr., Dalton — Director

William Barnwell, Dalton — Alternate Director

Eighth District Medical Society

Joe C. Stubbs, Valdosta — Director

S. William Clark, Jr., Waycross — Alternate Director

Ninth District Medical Society

John E. Fowler, Clayton — Director

Joe L. Griffith, Commerce — Alternate Director

Richard L. Greene, MAG's Legal Counsel (Right Front), Drs. Albert Carr and Gwynne Brunt are among those shown here at the House meeting.

Clayton-Fayette County Medical Society
F. Peter Nicholson, Riverdale — Director
Stephen P. Auda, Fayetteville — Alternate Director

Cobb County Medical Society
Ronald P. Roper, Marietta — Alternate Director

DeKalb Medical Society
Roy W. Vandiver, Decatur — Director
Walker L. Ray, Decatur — Alternate Director

Floyd-Polk-Chattooga Medical Society
Joel Todino, Rome — Director
L. C. Rigas, Rome — Alternate Director

Medical Association of Atlanta
Thomas J. Anderson, Atlanta — Director
Gwynne T. Brunt, Jr., Atlanta — Director
Teresa E. Clark, Atlanta — Alternate Director
Alan L. Plummer, Atlanta — Alternate Director
Hugh S. Thompson, Atlanta — Alternate Director
(to fill Dr. Brunt's unexpired term of 1991)

Richmond County Medical Society
Luther M. Thomas, Augusta — Director
James L. O'Quinn, Augusta — Director
Sumner Fishbein, Augusta — Alternate Director
Donald C. Abele, Augusta — Alternate Director

Reports of Officers

President's Report — Rec. 1 — referred to Ref. Comm. B; Rec. 2 — referred to Ref. Comm. C.

President-Elect's Report — Not referred.

Immediate Past President's Report — Rec. 1 — referred to Ref. Comm. C; Rec. 2 — referred to Ref. Comm. F.

Secretary's Report — Ref. Comm. B.

Chairman, Georgia Delegation to AMA — Report not referred.

Reports of Directors

The following Directors' reports were not referred to a Reference Committee: First District Medical Society, Second District Medical Society, Third District Medical Society, Fourth District Medical Society, Fifth District Medical Society, Sixth District Medical Society, Seventh District Medical Society, Eighth District Medical Society, Ninth District Medical Society, Tenth District Medical Society, Bibb County Medical Society, Clayton-Fayette County Medical Society, Cobb County Medical Society, Crawford W. Long Medical Society, Dougherty County Medical Society, Floyd-Polk-Chattooga Medical Society, Georgia Medical Society, Gwinnett-Forsyth Medical Society, Hall County Medical Society, Muscogee County Medical Society, and Richmond County Medical Society.

Reports of Sections

Medical Student Section — Report not referred.

Young Physicians Section — Report not referred.

Hospital Medical Staff Section — Report referred to Ref. Comm. A.

Special Reports

MAG Mutual Insurance Company's report — Not referred.

Journal of the Medical Association of Georgia's report — Report not referred.

Auxiliary's report — Not referred.

Georgia Medical Care Foundation's report — Not referred.

Reports of Committees

Access to Medical Care — Rec. 1, 2 — referred to Ref. Comm. D; Rec. 3 — referred to Ref. Comm. B.

Auxiliary — not referred.

Cancer — Referred to Ref. Comm. B.

Continuing Medical Education — Not referred.

Emergency Medical Services — Referred to Ref. Comm. A.

Impaired Physicians — Referred to Ref. Comm. A.

Legislative Council — Referred to Ref. Comm. C.

Maternal & Infant Health — Not referred.

Medical Aspects of Sports — Referred Rec. 1 to Ref. Comm. C; referred Recs. 2, 3, 4 to Ref. Comm. B.

Medical Practice — Referred to Ref. Comm. B.

Medical Schools — Referred to Ref. Comm. A.

Membership Expansion & Involvement — Not referred.

Prison Health Care — Not referred.

Public Health — Referred Rec. 1 to Ref. Comm. B; referred, Rec. 2 to Ref. Comm. F.

Public Relations Council — Referred to Ref. Comm. F.

Scientific Assembly — Not referred.

Specialty Society Relations — Not referred.

Third Party Payors — Referred Rec. 1, 2 to Ref. Comm. B; referred Recs. 3, 4, 5 to Ref. Comm. A.

Ad Hoc on AIDS — Referred to Ref. Comm. A.

Ad Hoc on Physicians Dispensing and Drugs — Not referred.

Ad Hoc on PRO Review — Not referred.

Resolutions

Law Regarding Blood Alcohol Levels — Res. 1: Referred to Ref. Comm. C.

Honorary Dues Exempt Status for Physicians in High Elected or Appointed Offices — Res. 2: Referred to Ref. Comm. C.

Qualifications for Life Membership — Res. 3: Referred to Ref. Comm. C&B.

Georgia Medical Care Foundation Board — Res. 4: Referred to Ref. Comm. B.

Cost of Home Health Care — Res. 5: Referred to Ref. Comm. B.

Committee on Scientific Assembly — Res. 6: Referred to Rec. 1 to Ref. Comm. A and Rec. 2 to Ref. Comm. C&B.

Medical Support for 1996 Olympics — Res. 7: Referred to Ref. Comm. A.

AMA Investigation of Medicare — Res. 8: Referred to Ref. Comm. B.

Legal Action Against Medicare — Res. 9: Referred to Ref. Comm. B.

Profit by Referral — Res. 10: Referred to Ref. Comm. C.

Universal Access to Health Care — Res. 11: Referred to Ref. Comm. C.

National Practitioner Data Bank — Res. 12: Referred to Ref. Comm. D.

Non-Discrimination Against Victims of Illness — Res. 13: Referred to Ref. Comm. C.

Means Test for Proposed Medicare Recipients — Res. 14: Referred to Ref. Comm. B.

PRO Immunity — Res. 15: Referred to Ref. Comm. C.

AMA Membership for MAG Officers — Res. 16: Referred to Ref. Comm. A.

Community Service — Res. 17: Referred to Ref. Comm. D.

Medical Family — Res. 18: Referred to Ref. Comm. D.

Geographical Variances in Medicare Reimbursement — Res. 19: Referred to Ref. Comm. C.

Established Medicare Payment — Res. 20: Referred to Ref. Comm. B.

Consideration of Service Site in Reimbursement — Res. 21: Referred to Ref. Comm. B.

Billing by Physicians for Coverage by Colleagues — Res. 22: Referred to Ref. Comm. B.

Abuses in Home Health Care — Res. 23: Referred to Ref. Comm. B.

Non-Emergency Transport Services — Res. 24: Referred to Ref. Comm. C.

Generic Drugs — Res. 25: Referred to Ref. Comm. C.

Medicaid Precertification — Res. 26: Referred to Ref. Comm. B.

Living Wills and Health Care Powers of Attorney — Res. 27: Referred to Ref. Comm. D.

Medicaid Precertification — Res. 28: Referred to Ref. Comm. B.

ATV Licensure and Age for Marketing — Res. 29: Referred Rec. 1 to Ref. Comm. C and Rec. 2 to Ref. Comm. D.

Alcohol Abuse Education in Elementary Schools — Res. 30: Referred Rec. 1 to Ref. Comm. F and Rec. 2 to Ref. Comm. D.

Drug Treatment Programs for Youth and Women — Res. 31: Referred to Ref. Comm. B.

MAG Directory — Res. 32: Referred to Ref. Comm. A.

Medical Student Liability Coverage on Out-of-State Rotations — Res. 33: Referred to Ref. Comm. D.

Congressional Lobbying — Res. 34: Referred to Ref. Comm. C.

AMA Executive Vice President — Res. 35: Referred to Ref. Comm. A.

Right to Privacy in Termination of Pregnancy — Res. 36: Referred to Ref. Comm. C.

Among the delegates shown here are Drs. Bill Clark, III, Bill Clark, Jr., Harrison "Jack" Rogers, and Irving Hellenga.

MAG Support of Hospital Medical Staff — Res. 37: Referred to Ref. Comm. B.

Abortion — Res. 38: Referred to Ref. Comm. C and Ref. Comm. B.

Appointments of Reference Committees

Reference Committee A

Donald H. Campbell, M.D., Chairman, Cobb; Charles W. McDowell, Jr., M.D., Vice-Chairman, DeKalb; William A. Wolff, M.D., Muscogee; John T. Yauger, M.D., Medical Assn. of Atlanta; John Ed Fowler, M.D., Stephens-Rabun; E. Dan DeLoach, M.D., Georgia Medical; Phillip K. Rhyne (Student), Bibb; and Joyce Butler, MAG Staff.

Reference Committee B

Alexander H. S. Weaver, Jr., M.D., Chairman, Bibb; Luther M. Thomas, Jr., M.D., Vice-Chairman, Richmond; Roland S. Summers, M.D., Georgia Medical; Robert Glenn Carter, M.D., St. John's Parish; Rodney L. Smith, M.D., Hall; Alva L. Mayes, Jr., M.D., Bibb; Frank E. Carlton, M.D., Georgia Medical; Jeffrey T. Nugent, M.D., Medical Assn. of Atlanta; Irving D. Hellenga, M.D., Stephens-Rabun; and Cam Taylor, MAG Staff.

Reference Committee C

James L. O'Quinn, M.D., Chairman, Richmond; Asa G. Yancey, M.D., Vice-Chairman, Medical Assn. of Atlanta; Albert A. Carr, M.D., Richmond; John S. Antalis, M.D., Whitfield-Murray; Roy W. Vandiver, M.D., DeKalb; Catherine S. Andrews, M.D., Cobb; Billy D. Burke, M.D., Floyd-Polk-Chattooga; Joe C. Stubbs, M.D., South Georgia; and Joe T. Wood, Sr., and Cynthia Haney, MAG Staff.

Reference Committee D

Alan Plummer, M.D., Chairman, Medical Assn. of Atlanta; Dan B. Stephens, M.D., Vice-Chairman, Cobb; Richard A. Wherry, M.D., Lumpkin; Thomas L. Haltom, M.D., Cobb; Robert A. Burns, M.D., Whitfield-Murray; L. T. Crimmins, M.D., Dougherty; John P. Heard, M.D., DeKalb; Michael E. Greene (Student), Bibb; Robert D. Gongaware, M.D., Georgia Medical; and Steve Davis, MAG Staff.

Reference Committee F

Joseph P. Bailey, Jr., M.D., Chairman, Richmond; H. G. Davis, Jr., M.D., Vice-Chairman, Worth; Sumner Fishbein, M.D., Richmond; Charles A. Lanford, M.D., Bibb; Gwynnee T. Brunt, M.D., Medical Assn. of Atlanta; William D. Logan, Jr., M.D., Medical Assn. of Atlanta; Walter M. Ligon, M.D., Cobb; and Karen Haughey, MAG Staff.

Reference Committee on Constitution & Bylaws

Joy A. Maxey, M.D., Chairman, DeKalb; Cecil L. Miller, M.D., Vice-Chairman, Gwinnett-Forsyth; William C. Acton, M.D., Bibb; Hugh S. Thompson, Jr., M.D., Medical Assn. of Atlanta; Ellis B. Keener, M.D., Hall; Edmund (Mac) Molnar, M.D., Muscogee; James F. Beattie, Jr., M.D., Walker-Catoosa-Dade; Kenneth L. Goldman, M.D., Muscogee; and Lynn Pearson, MAG Staff.

Credentials Committee

Bob G. Lanier, M.D., Chairman, Medical Assn. of Atlanta; Larry Brightwell, M.D., Muscogee; E. Capers Palmer, M.D., Troup; David R. Fern, M.D., DeKalb; Robert D. Gongaware, M.D., Georgia Medical.

Tellers Committee

J. K. Schellack, M.D., Medical Assn. of Atlanta; S. William Clark, III, M.D., Ware; C. Allen Woods, Jr., M.D., South Georgia; Philip Z. Israel, M.D., Cobb.

Adjournment

After several brief announcements, the Speaker adjourned the First Session of the House of Delegates at approximately 10 p.m.

Unreferred Reports

OFFICE OF THE PRESIDENT-ELECT

William C. Collins, M.D.

Time marches steadily forward and soon the awesome responsibility of the President of the Medical Association of Georgia shall no longer be an illusion but will be a fact as it is placed on my shoulders. I am filled with emotion running the gamut from a fear of failure to the immense pride I feel in being allowed to fill the shoes worn recently by such giants as Joe Nettles, Joe Bailey and all of the other competent and hard-working physicians who have held this post. It has been my pleasure to work closely with the last two Presidents and anything that I set out to accomplish will be simply carrying on the work that these two men have begun.

I think it is appropriate for me to outline a plan of action for the coming year to the House of Delegates for although official sanction may not be required in some cases I will gladly receive and greatly appreciate your ideas and input as to the appropriateness of these measures. I, of course, will work diligently with the Executive Committee and Board of Directors and the committee structure of the House and the Association to carry out any resolutions that the House of Delegates may outline for the Medical Association of Georgia to pursue in the coming months.

One particular goal will be to revitalize and revise the committee structure of the Medical Association of Georgia and make sure that every committee is functioning and has a specific charge for the coming year. The Executive Committee and I will be closely monitoring committee membership and activities in hopes that the committee structure can work as it has never worked before in solving problems relative to the health of Georgians and to the better working of the Medical Association of Georgia. I think it is always frustrating for a member to be appointed to a committee and find out that the committee does not function and really has no raison d'etre. We will definitely make this a priority item this year.

(L to R) Drs. Milton Johnson, Charles Lanford, and Alva Mayes — all from Macon.

Counsel from all of the senior staff has been received insofar as committee structure, projects, problems and other items to be addressed by your President, Executive Committee and Board of Directors this year. The staff, in my opinion, is probably the finest we have ever had. They are filled with enthusiasm, are hard-working and appear as dedicated a group as it has ever been my pleasure to work with.

The Executive Committee has thus far acted as a exploration group for the Long-range and Strategic Planning Committee. Building upon their work, I will appoint an independent committee this year to work under the able leadership of Dr. John Ed Fowler of Clayton, Georgia. I am hoping this will be a true Blue Ribbon Committee, made up of young and old, male and female, black and white — all of the individual characteristics of the Medical Association of Georgia which will go toward making it truly an organization for the Nineties and thereafter. A charge and composition of this committee will be forthcoming.

During the coming months, the Executive Committee will establish a liaison with appropriate representatives of the Georgia Bar Association to outline common interests and problems, with the purpose of bringing these two groups together as much as is possible. We have certain areas where we will not be able to totally agree with the Bar Association, but I think we have many common areas upon which to build a foundation of trust and establish a working relationship which will be of value in years to come. We will attempt to establish similar relationships with other professional groups such as the Georgia Nurses Association and the DHR Board. We will make a special effort to meet with those specialty societies that have their own lobbyists in an effort to discuss terms of mutual interest and to better coordinate the representation of organized medicine in the Legislature.

Across the state, I have recognized that problems with insurance companies and their subsidiary utilization review "first cousins," are posing the most frustrating problem Georgia's physicians must face. We will re-invigorate the Third Party Payors Committee and will dedicate more time on a staff level and more expertise to better solving our problems in this area. We hope to establish a MAG "hotline" where physicians can report all problems with insurance companies. The calls will be tabulated so that cumulative evidence will be available when action is taken.

Thomas J. Anderson, Jr., M.D., of Atlanta, Chairman of MAG's Board of Directors.

Special attention will be given to adolescent health care through the establishment of an Adolescent Health Care Committee. Along the same lines, we will work to revitalize the Sports Medicine Committee in an effort to provide leadership and better care for students engaging in athletics in high schools and junior high schools across our State. Review of appropriate insurance coverage and requiring the presence of trainers at practices will be topics for discussion and, we hope, action.

The PR Committee will receive increased attention under the capable leadership of Jeff Nugent and an effort made to spread the good news of what the Medical Association of Georgia's members are already doing for the health needs of this State. We have not patted ourselves on the back enough for the countless hours that so many of you give to community service and community medical care. Volunteerism will be encouraged at all levels of the Medical Association of Georgia and our efforts, both new and continuing, will be publicized. The story is there — it simply needs to be told.

Efforts will be made to encourage ideas and suggestions for potential legislative activity at the very outset so that our legislative agenda can be formulated early on. We will carefully coordinate our plans with the specialty societies involved and with our own Legislative Council to ensure another successful legislative session in 1991.

This is my twentieth year involved in organized medicine. I promise you that in the ensuring year, as much as is humanly possible, my every thought and breath will be toward making the Medical Association of Georgia a better organization than it was when I found it. I challenge each of you to adopt this as your individual credo. While individually we each might be a simple ripple in the water, united we can become a tidal wave. Join me — I need your help.

OFFICE OF THE AMA DELEGATION CHAIRMAN

C. Emory Bohler, M.D.

The AMA House of Delegates met in Honolulu, December 3-6, 1989. This was a very busy meeting, with 187 resolutions and 79 Board and Council reports to consider. The House took positions on some far-reaching issues of vital important to the practicing physician.

The House is composed as follows, with 435 delegates being seated:

— 347 delegates representing state medical associations
— 78 delegates representing national medical specialty societies
— 10 delegates representing medical students, resident physicians, hospital medical staff, young physicians, Army, Navy, Air Force, USPHS, and the Veterans Administration.

Address of the President: Alan R. Nelson, M.D., AMA President, declaring that "the AMA works," cited an impressive list of accomplishments as an answer to the proverbial questions, "What does the AMA do for me?" He included:

- the defeat of mandatory assignment four times in the past three Congresses
- the fact that the AMA is the world's largest publisher of scientific information
- the defeat of expenditure targets in the budget bill
- the AMA's commitment to NIH funding to protect the stability and integrity of medical research in the U.S.
- the AMA's considerable activities in communicating medicine's story to the public (i.e. weekly news releases to 3,000 reporters, meeting with editorial boards, American Medical Television reaches over 50,000 physicians and 800,000 lay people each month and American Medical Radio News is used by 500 radio stations daily)

Dr. Nelson urged the nation's physicians to get involved and join the AMA as "your best investment in the future." He expressed concern that "the frustration and disillusionment being expressed by physicians in America will lead

them to throw up their hands in despair rather than raise up their arms in support."

Lauro F. Cavazos, Ph.D., U.S. Secretary of Education: Dr. Cavazos addressed the opening session of the House of Delegates. A former medical school dean, Dr. Cavazos declared that "our medical schools are at the forefront of curricular innovation and continue to attract the finest students." He credited the AMA as playing "an essential role in assuring that educational quality is maintained."

Dr. Cavazos called upon the delegates for assistance in improving and restructuring our nation's system of education. He said, "without a well-educated citizenry, the United States is in danger of becoming what has been described as the world's only fully industrialized third-world nation."

Dr. Cavazos called for a major restructuring of the nation's educational system that provided: 1) early childhood education, 2) safe, drug free schools for all of America's children and 3) support for teachers from physician volunteers.

Strengthening the AMA — Fiscal Responsibility and Oversight (Report QQ of the Board of Trustees) — The House of Delegates approved a comprehensive report of the Board which responded to recent incidents reported in a Chicago newspaper. The report outlined the results of the investigation conducted by independent legal counsel and listed actions by the Board to assure the continued exercise of its fiduciary responsibilities.

In a speech before the House, the Executive Vice President admitted his error and accepted responsibility for the decisions. He expressed his support for the changes recommended by the Board to provide closer communication and control and asked the House to consider that "on balance my contributions outweigh my mistakes."

At the reference committee hearing, Dr. Sammons and Dr. Ring, Chairman of the Board, answered detailed questions about Association finances and operations. When the House reconvened on Tuesday, it became apparent that the Board's position would receive nearly unanimous support from the delegates.

The report listed the following actions by the Board:

1. Jenner & Block (independent legal counsel) will continue its broad investigation and expand it as they recommend and the Board deems necessary, and will report to the Board.

2. AMA General Counsel has been directed to continue to take all appropriate action necessary to recover any and all funds due the AMA. It is unlikely that there will be full recovery of funds lost from the Noffke transactions.

3. To strengthen Board oversight of the Association and to define limitations of EVP authority, there will be a restructuring of Board committees to include:

a. A Finance Committee with broad authority to review and monitor the fiscal policies, procedures, and finances of the Association.
b. An Audit Committee to review and monitor the auditing activities of the Association.
c. A Compensation Committee to review performance and authorize the compensation of senior staff.

4. The Board directed that new outside auditors be retained for 1990.

5. The Board recognized the strong leadership of and contributions to the Association by Dr. James H. Sammons since he became EVP in 1974.

6. To improve the operations of the AMA, the Board will formulate and institute specifically defined limits upon the authority of the EVP in respect to monetary, compensation and health policy matters to conform to the exercise of the Board's fiduciary responsibilities.

7. All expenditures, unless otherwise budgeted, in excess of $100,000, shall be approved by the Chairman of the Board.

8. AMA policies on providing loans to employees shall be evaluated and defined by the Board.

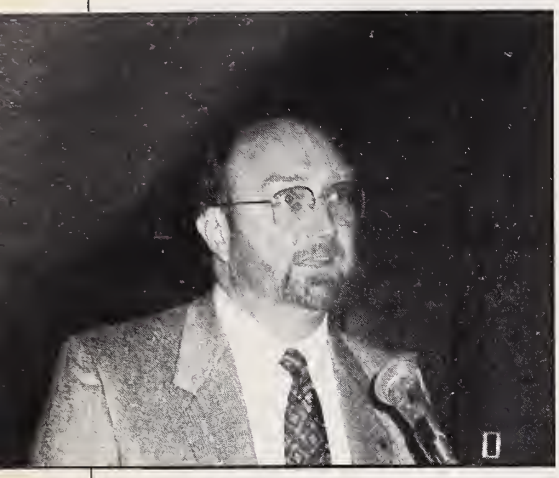
9. The Board reaffirmed the value of the present activity of Reference Committee F, a special reference committee of the House of Delegates meeting quarterly with the Finance Committee, to maintain uniform financial communication as previously directed by the House.

Noting that Dr. Sammons had previously planned to retire from his position as Executive Vice President and leave the employment of the AMA on March 31, 1991, when his current contract expires, the Board accepted his decision. To assure an orderly transition in administrative leadership, a search process will immediately begin to identify a successor for the position of AMA Executive Vice President.

The report also stated that the Board will continue the development and refinement of these policies and will report the findings of its continuing investigation and its further actions to the House at the 1990 Annual Meeting.

AIDS: The House approved a major policy update on the medical, legal, and social implications of AIDS and HIV infection. The Board report addressed a number of issues related to education, research, national policy, financing media coverage, and the prevalence and incidence of AIDS including the first issue listed below that was introduced by the Georgia delegation:

- recommended development of hospital staff guidelines to allow HIV testing of a patient at the physician's discretion without the patient's consent in case of exposure of body fluids.



Roy W. Vandiver, M.D., of Stone Mountain, MAG's new First Vice President.

- recommended contact-tracing and notification of needle partners.
- recommended that the AMA Council on Medical Service study the cost of care for patients in each stage of HIV infection and estimate the number of people in each stage now and in five years.
- pledged ongoing support for funding for research, education, and patient care, as well as for alternatives to inpatient care.
- vowed to work with other physician groups, public health officials, and universities to advance training for primary care MDs and specialties.
- encourage MDs to provide information to patients about HIV prevention and to become more involved in the care of HIV-infected patients.
- endorsed institutional indemnification of medical students and resident physicians infected as a result of patient contact.
- said AMA would consult with appropriate federal agencies and drug manufacturers about the expansion of AIDS drugs.
- urged MDs to take comprehensive and thorough sex and drug histories in a non-judgmental fashion.
- asked federal and state agencies to establish rigorous proficiency testing and quality control procedures for testing labs frequently and regularly.
- reaffirmed its commitment to mandatory testing of inmates in federal and state prisons and supported mandatory testing of all newborns in high prevalence areas.

In other AIDS-related actions, the House:

- encouraged stage legislation to establish requirements for reporting and case follow-up for serious contagious disease, including HIV infection.
- requested that the Food and Drug Administration address the problem of readable instructions for condoms.
- recommended that the FDA not allow home test kits for HIV.

Drug Abuse in the United States: The House considered a Board report and several resolutions related to drug abuse. The report states that America's drug epidemic has evolved in recent years from an urban plight to a national crisis. The Board pledged its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The report recommended that the AMA:

1. Cooperate in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of maternal drug and alcohol use.

2. Encourage the development of model alcohol and drug treatment programs, complete with an evaluation component, that are designed to meet the special needs of pregnant women through a comprehensive array of essential services.

3. Urge physicians to routinely screen all pregnant women, and those of childbearing age for drug and alcohol use, and to follow-up positive screens with appropriate interventions and referrals.

4. Pursue the development of educational materials for physicians and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the Board encourages further collaboration with the Partnership for a Drug-free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use.

5. Urge the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Federal Office for Substance Abuse Prevention to continue to support research and intervention strategies.

6. Urge that public policy be predicated on the understanding that alcoholism and drug dependence are diseases characterized by compulsive use in the face of adverse consequences.

7. Affirm the concept that substance abuse is a disease and develop model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus, and resultant offspring.

8. Call for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.

In a related action, the House adopted a resolution, entitled "Substance Abuse as a Public Health Hazard," that called upon the AMA to:

- recognize that substance abuse is a major health problem in the United States today and that its solution requires a multifaceted approach
- declare substance abuse its number one public health priority
- take a positive stance as a leader in matters concerning substance abuse
- study innovative approaches to the elimination of substance abuse dependencies and their resultant street crime, including approaches which have been used in other nations.

Prevention of Drunk Driving: The House adopted a resolution introduced by the Young Physicians Section that addressed the issue of the involvement of alcohol as a leading cause of morbidity and mortality in motor vehicle accidents. The House voted to:

- encourage state medical societies to urge their state legislators to adopt a blood alcohol level of 0.05 percent as per se illegal for driving
- work with Congress to make federal highway funds to states contingent upon state adoption of a blood alcohol level of 0.05 percent as per se illegal for driving.

Frozen Pre-embryos: The House approved a report that discusses the legal and ethical issues created by the freezing of human pre-embryos and offers guidelines as to the rights of the gamete providers and the disposition of the pre-embryos.

ABMS Yellow Page Listing: The House adopted a resolution introduced by the District of Columbia Delegation that called upon the AMA to:

- urge the American Board of Medical Specialties (ABMS) to abandon the entrepreneurial endeavor of placing display advertisments in the major Yellow Pages telephone directories where board certified specialists are located.
- insist that truth in advertising demands that ABMS state to all callers that their display listings may not represent a complete listing of all board certified specialists.

Health Insurance Coverage for Uninsured: The House adopted a resolution that addressed the problem of having an estimated 37 million Americans without health insurance. Introduced by the American Academy of Family Physicians, the resolution called upon the AMA to reaffirm its support for ensuring access to health care for the uninsured:

- through a combination of employer-sponsored coverage
- through other private approaches such as risk pools and the AMA proposed restructuring of Medicaid and Medicare programs.

The resolution also asked the AMA to aggressively pursue implementation of a program ensuring health care access for the uninsured as a high legislative priority beginning in the 101st Congress.

Dependent Uninsured Coverage: In a related action, the House approved a resolution, introduced by the Hospital Medical Staff Section, calling for an AMA study of the health insurance coverage for the uninsured "dependent" population.

Billing for Cross-Coverage: A number of resolutions addressed physician dissatisfaction with the referral of Medicare, Medicaid, and most private payors to allow solo practitioners to bill for services provided by covering physicians.

The House approved a policy promoted by your Georgia Delegation calling on the AMA:

"to pursue all appropriate legislative, regulatory, and administrative means to amend, or eliminate the inappropriate enforcement of the Social Security Act and/or Medicare regulations in order to make it possible for physicians in solo or group practice to bill and receive payment for professional services to their Medicare patients rendered by colleagues who provide them with traditional short-term coverage."

Funding for the AMA's Physicians' Assistance Program: Several state delegations cosponsored a resolution asking the AMA to continue to adequately fund and maintain an impaired physicians program or "Physicians' Assistance Program." The resolution, which was adopted as amended, directed that the charge of the program will include, but not be limited to:

- promoting state medical society impaired physician programs and medical student impairment programs
- providing technical assistance to state programs
- conducting scientific and socioeconomics research
- hosting an annual conference to share research and exchange ideas on the field of physician impairment.

FIRST DISTRICT MEDICAL SOCIETY

Gary Loveless, M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Ogeechee River C. Emory Bohler (Pres.) Brooklet	45	31	46	37
Burke Pamela T. Stitt, Waynesboro	6	3	6	4
Emanuel T.M. Tamblyn, Ill, Swainsboro	6	3	7	2
Laurens Andy F. Williamson, Dublin	45	22	44	19
Southeast Georgia Michael D. Gross, Vidalia	20	4	17	4
St. Johns Parish Grace C. Bautista, Hinesville	9	2	9	1
	131	65	129	67

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

SECOND DISTRICT MEDICAL SOCIETY

W. Charles Pfister, M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Colquitt Charles Gary Lodge, Moultrie	33	16	35	18
Decatur-Seminole Don R. Robinson, Bainbridge	19	12	23	16
Mitchell A.A. McNeill, Jr., Camilla	5	2	6	3
Southwest Georgia Virendra M. Saxena (Pres.), Fort Gaines	11	4	10	5
Thomas Area W.A. Lardin, Thomasville	62	38	62	36
Tift Roger McLendon, Tifton	54	27	53	26
Worth Harmer O. Eason, Jr, Sylvester	4	1	1	3
	188	100	193	107

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

THIRD DISTRICT MEDICAL SOCIETY

V.W. McEver, Jr., M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Flint John B. Adams, Jr., Cordele	13	4	13	4
Peachbelt Virgle W. McEver, III, Warner Robins	56	38	54	43
Randolph-Stewart-Terrell Thomas M. Allen, Dawson	4	1	3	1
Sumter William R. Anderson, Americus	26	17	28	17
	99	60	98	65

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

DEKALB MEDICAL SOCIETY

Charles McDowell, Jr., M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
DeKalb David R. Fern, Decatur	306	181	298	189

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

MEDICAL ASSOCIATION OF ATLANTA

William Waters, III, M.D., Director
T.J. Anderson, Jr., M.D., Director
J. Harold Harrison, M.D., Director
Jeffrey T. Nugent, M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
M.A.A. William L. Dobes, Jr., Atlanta	1750	984	1667	1045

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

SIXTH DISTRICT MEDICAL SOCIETY

Werner A. Linz, M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Coweta Georgia Theriot, Newnan	32	18	29	17
Henry (no officers)	3	2	3	2
Meriwether-Harris-Talbot James Knowles, Warm Springs	9	4	9	4
Spalding S.G. Patel, Griffin	51	18	50	21
Troup Richard L. Ingram, LaGrange	65	52	71	58
Upson James M. Braden, Thomaston	24	9	23	8
	184	103	185	110

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

SEVENTH DISTRICT MEDICAL SOCIETY

William H. Lumpkin, M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Bartow John T. Perry, Cartersville	15	8	14	7
Carroll-Haralson Frederick Martin, Carrollton	38	21	41	24
Gordon Ted M. Pennel, Calhoun	22	7	22	9
Douglas Joseph Bussey, Douglasville	25	15	28	15
Walker-Catoosa-Dade Fred J. Duhon, Ft. Oglethorpe	44	26	43	26
Whitfield-Murray William Blackman, III, Dalton	81	64	90	67
	225	141	238	148

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

EIGHTH DISTRICT MEDICAL SOCIETY

Joe C. Stubbs, M.D., Director

This year, the Eighth District Medical Society met on Thursday, September 7, 1989, at the Okeefenokee Golf and Country Club outside Waycross. The Society elected Turner Wayne Rentz, M.D., as President, Spurgeon William Clark, III, M.D., Secretary, and S. William Clark, Jr., M.D., as Alternate Director.

Dr. Rentz, of Brunswick, has served as representative for the MAG House of Delegates, President and Secretary of the Glynn County Medical Society, and has participated actively as a member of the Georgia Surgical Society. Among his many involvements with the Young Physicians Section and AMA Delegation, Spurgeon William Clark, III, M.D., actively and enthusiastically served as Secretary of the Ware County Medical Society during the past three years, in addition to serving the MAG and AMA delegation and the Georgia Society of Ophthalmology. Our long-time member and colleague, S. William Clark, Jr., M.D., has served organized medicine in many capacities, including AMA Delegate and MAG President, President and Secretary of the Ware County Medical Society, Councilor of the American Academy of Ophthalmology, President of the Georgia Health Network, and a very active member of the Georgia Society of Ophthalmology.

The District would like to take this opportunity to thank Dr. Neal Yeomans, who served as the Eighth District Secretary for over fifteen years. Dr. Yeomans did an excellent job as District Secretary and should be commended by all. In addition to his many accomplishments and service to organized medicine, Dr.

Yeomans has served on the MAG and AMA delegations, MAG's Committees on Area Wide Health Planning and Professional Conduct and Medical Ethics, and has been an active member of both the Georgia Thoracic Society and the Georgia Radiological Society.

As a mandate of the 1989 House of Delegates, the MAG Board of Directors was instructed to make a decision at its January, 1990, meeting, concerning the on-going problems of societies which don't comply with the MAG Bylaws specifications of maintaining at least five (active/life) members and those societies which have no officers listed or have elected non-MAG members as officers.

The Camden-Charlton Medical Society had unofficially requested that Camden and Charlton counties split and form spearate societies, however, no action has been taken as the members have not further pursued the reorganization. Officers and others in the District have been working with the society to help it resolve any problems.

Although the Coffee County Medical Society has twelve members, it has had no officers listed with MAG and has elected both President and Secretary who are non-MAG members. MAG staff has contacted the Society's new officers but has been notified both the President and Secretary do not intend to join MAG. Among others, the MAG Membership Expansion and Involvement Committee is working with the non-members in an attempt to positively present medical association activities so the physicians will become a part of their medical societies.

At the January, 1990, Board of Directors meeting, MAG's President, Joe L. Nettles, M.D., of Savannah, indicated he wished to personally contact each society that is experiencing problems.

The next meeting of the Eighth District Medical Society will be held Sept. 6, 1990, again at the Okeefenokee Golf and Country Club.

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Altamaha	7	4	8	4
Rogelio C. Poblete (Pres.), Baxley				
Ben Hill-Irwin	9	9	8	5
William J. Hammond, Fitzgerald				
Coffee (no officers)	12	3	11	4
Camden-Charlton	11	4	13	5
Joseph D. Proctor, Jr., Kingsland				
Glynn	80	41	86	45
Renee E. Godbey, Brunswick				
Ocmulgee	20	13	18	10
Reuben Roberts, Hawkinsville				
South Georgia	89	43	90	48
C. Allen Woods, Jr., Valdosta				
Ware	60	29	57	28
S. William Clark, III, Waycross				
Wayne	16	2	17	3
	340	148	308	152

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

NINTH DISTRICT MEDICAL SOCIETY

Rupert H. Bramblett, M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Barrow	11	5	11	5
Garey H. Huff, Winder				
Blue Ridge	11	4	12	5
Robert A. Bond (Pres.), Ellijay				
Elbert	8	6	9	5
Robert David Mize, Elberton				
Cherokee-Pickens	27	11	29	11
John A. Check, Canton				
Habersham	11	6	14	8
James G. Hamilton, Jr., Clarkesville				
Hart	6	2	5	1
J.R. Merrill, Hartwell				
Jackson-Banks	8	6	11	7
Susan Alexander, Commerce				
Lumpkin	9	5	6	6
(no officers)				
Stephens-Rabun	35	7	36	10
Elton L. Copelan, Toccoa	126	52	133	58

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

TENTH DISTRICT MEDICAL SOCIETY

William M. Headley, M.D., Director

Counties and Secretaries	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Baldwin	47	22	50	21
Armando V. Roig, Milledgeville				
Franklin	6	4	6	3
Hoyt Crump, Royston				
Jefferson	0	0	1	0
(no officers)				
McDuffie	2	1	1	1
M. Frank Powell (Pres.), Thomson				
Newton-Rockdale	49	22	48	19
Thomas L. Rodziewicz, Conyers				
Oconee Valley	9	2	11	4
William Buhrow, Eatonton				
Walton	17	7	16	8
Lisa Vickery (Pres.), Monroe				
Washington	7	1	9	1
Earle M. Taylor, Sandersville				
Wilkes	4	3	4	3
John E. Pollock, Washington	141	62	146	60

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

BIBB COUNTY MEDICAL SOCIETY

Charles A. Lanford, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Bibb	358	235	370	257
Bruce S. Allen, Macon				

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

CLAYTON-FAYETTE COUNTY MEDICAL SOCIETY

Selwyn T. Hartley, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Clayton-Fayette Robert A. Robbins, Riverdale	130	55	142	52

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

COBB COUNTY MEDICAL SOCIETY

Dan B. Stephens, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Cobb Catherine S. Andrews, Kennesaw	369	213	394	231

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

CRAWFORD W. LONG MEDICAL SOCIETY

E. Van Herrin, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Crawford W. Long Warren B. Horn, Athens	120	77	118	76

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

DOUGHERTY COUNTY MEDICAL SOCIETY

Carl V. Hancock, Jr., M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Doughtery Lamar H. Moree, Albany	150	102	150	99

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

FLOYD-POLK CHATTOOGA COUNTY MEDICAL SOCIETY

Joel Todino, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Floyd-Polk-Chattooga John T. Collins, Rome	144	79	140	87

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

GEORGIA MEDICAL SOCIETY

J. Patrick Evans, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Georgia Medical Society Michael Zoller, Savannah	296	198	317	194

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

GWINNETT-FORSYTH MEDICAL SOCIETY

Rupert H. Bramblett, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Gwinett-Forsyth Rupert H. Bramblett, Cumming	106	53	125	58

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

HALL COUNTY MEDICAL SOCIETY

John W. Darden, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Hall William B. Jones, Gainesville	138	93	133	84

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

MUSCOGEE COUNTY MEDICAL SOCIETY

E.M. Molnar, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Muscogee George B. Hubbard, Columbus	537	300	303	171

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

RICHMOND COUNTY MEDICAL SOCIETY

Luther M. Thomas, Jr., M.D., Director
James L. O'Quinn, M.D., Director

County and Secretary	Members 12/31/88		Members 12/31/89	
	MAG	*AMA**	*MAG*	*AMA**
Richmond Willard Quillian, III, Augusta	537	300	534	309

*Members paying AMA dues via MAG
[MAG membership figures above reflect active and life members]

MEDICAL STUDENT SECTION

Adela Casas, Chair

This past year has been one of the busiest for MAG's Medical Student Section, due largely to the extremely vigorous leadership of Phillip K. Rhyne, from whom I assumed chairmanship of our Section last February 3. Here are what I perceive to be our major accomplishments:

1. Student participation at the AMA House of Delegates Interim Meeting. Sixteen medical students from Emory, Mercer and the Medical College of Georgia Schools of Medicine attended the AMA-Medical Student Section Assembly, last December 1-3. Funding wasn't easy, as we used a combination of personal savings, chapter funds, school budgets and generous allocations from MAG to make our participation possible. Our Assembly agenda was full, but perhaps the biggest action coming out from the meeting was the AMA House of Delegates' endorsement of a single examination for licensure. (Previously, the AMA had supported both the use of the National Board and FLEX.)

2. Publication of our MAG MSS newsletter, "Murmurs." After a year's hiatus, we cranked out an attractive, informative four page issue of our state students' newsletter. It was well received by students at the four schools, especially as it reported on various chapters' activities, state and national student news, etc.

3. Participation in the MAG House. We wish to thank again the Delegates of the Medical Association of Georgia for voting last year to grant our Section a voting Delegate in the House. We are well represented this year at Callaway, and hope to continue our involvement in MAG's policy-making through several resolutions submitted to this house.

4. MAG MSS Interim Meeting, Atlanta, last September 23. Our Section held its semiannual meeting at Morehouse on September 23, 1989. Sixteen students represented all four schools as we reported on chapter projects such as AIDS education in public schools.

5. Annual Meeting, February 3. We are delighted that some 25 students attended the MAG Leadership Conference in Atlanta last February 3, and also participated that day in our MAG-MSS Annual Meeting. We approved a budget for the MAG Finance Committee to consider in funding our Section for 1990-91, discussed ongoing projects, and elected officers. Our Section officers for 1990-91 are, accordingly:

Chair — Adela Casas, M.C.G.
Vice-Chair — David Arnett, Mercer
Interim Secretary/Treasurer — Phil Rhyne, Mercer
MAG Delegate — Dominick Ferro, Emory
MAG Alternate — Angela Vick, M.C.G.

6. Drew Award. As authorized by the MAG House last year, the Medical Student Section has established an award to recognize "persons, who are not members of the Medical Student Section, whose services to the Medical Association of Georgia Medical Student Section, medical education, the medical profession, and/or humanity are exemplary." Our very first MAG MSS Charles R. Drew, M.D. Award will be presented at this year's House of Delegates.

7. Students at Board meetings. So that MAG's leadership can be better informed of our Section's activities, and vice versa, this year we determined to try to have at least one Student at each meeting of the MAG Board of Directors. Thus, last January in Albany, Phil Rhyne, Mike Greene and Bill Haddock attended the MAG Board meeting.

* * *

We are extremely grateful to the MAG for the chance to participate in this Association and to become involved in organized medicine generally. We pledge ourselves to continue our participation and involvement.

YOUNG PHYSICIANS SECTION

Joy A. Maxey, M.D., Chairman

The Medical Association of Georgia Young Physicians Section, created two years ago, is not only young, but active and growing.

At last year's MAG House of Delegates some 30 young Delegates and Alternates gathered in two separate "YPS Forum" meetings to review the various resolutions, determine young physicians' positions and how they would voice them at Reference Committees. We also held elections and discussed continued activities of the Section.

In addition to our YPS Forums at the House, each year we also hold a "Young Physicians' Luncheon" during the MAG Leadership Conference. This past February 3, 1990,

during the Leadership meeting, we were pleased to have had State Representative Terry Coleman address us. Representative Coleman gave an excellent presentation to us on the need for our political involvement. This message, coupled with young physicians' significant attendance at the past several Leadership Conferences (over 20% of all attendees last February), suggests that younger members of MAG do indeed have an interest in helping to direct our professional organization and shape its policies.

Young Physicians, by definition, are under 40 years of age or within their first five years of practice. Earlier this year we identified some 3,000 young physicians in Georgia who are not members of MAG. We prepared an elaborate membership recruitment packet and mailed it to all of these physicians. Responses are just now coming in, but already MAG has gained 25 new young physician members, enough for us to pay all costs of the mailing.

We plan to keep up our activities this coming year under our new officers for 1990-91. The MAG Young Physicians Section Governing Council members are as follows:

Chairman: Thomas L. Haltom, Jr., M.D.; Vice Chairman: James F. Beattie, M.D.; Secretary/Treasurer: R. Glenn Carter, M.D.; Member-At-Large: John Antalis, M.D.; Member-At-Large: Eugene H. Jackson, M.D.; Member-At-Large: John S. Kennedy, M.D.

MAG YPS Delegation to AMA: Joy A. Maxey, M.D.: Delegate; James F. Beattie, M.D.: Alternate Delegate.

AMA YPS Delegate to AMA House: S. William Clark, III, M.D.

Once again, we wish to thank the Medical Association of Georgia leadership for supporting our activities. We're glad to be doing our part for the continued growth of MAG.

Joy A. Maxey, M.D., of Atlanta, Chairman of the Young Physicians Section; and J. K. Shellack, M.D., of Atlanta, member of the Tellers Committee for the House of Delegates.

MAG MUTUAL INSURANCE COMPANY

Charles D. Hollis, Jr., M.D.

MAG Mutual is owned and operated by Georgia physicians. Its formation was authorized by the MAG House of Delegates. Physician involvement has continued to make possible stable growth in many ways which will be enunciated in this report.

By the end of 1989, MAG Mutual insured 3,840 physicians, more than any other insurance company in Georgia. MAG Mutual is now the third largest domestic property/casualty insurance company in Georgia and has become the nineteenth largest medical professional liability insurance company in the United States. This growth was made possible only by the enthusiastic support of the physicians in Georgia.

Along with growth, several innovations were added to the "MAG Mutual Difference." Because of the decrease in frequency of claims, independent actuaries confirmed that management could approve 22% rate reduction; the first rate reduction for our company and in fact by any professional liability carrier for many years. A combination of loss prevention efforts and tort reforms resulted in lower frequency of claims.

Other significant "differences" included a reduction to age 60 in the age a physician can retire without additional premium for a reporting endorsement (tail coverage). Other premium credits were continued including the 50% re-

duction for new physicians and discounts for the semi-retired, groups of four or more doctors, and attendance at loss prevention seminars. The primary commercial competitor announced this year a 50% premium discount for new physicians just out of residency, one of the features which MAG Mutual has offered since our inception in 1982. It was possible to enhance the LEAD Program — Loss Excellence Appreciation Discount — in essence doubling the discounts up to a maximum potential of 20% per year without paid losses after ten years with MAG Mutual.

SURF — the reinsurance company formed through a joint venture with Alabama, North Carolina and Kentucky — was activated and is now functioning with the expectation of reinsurance savings. This historically has been a very profitable layer of reinsurance for Georgia physicians, and retaining a portion of this protection will help minimize reinsurance costs and help stabilize premiums.

MAG Mutual continued to work with MAG in its efforts at legislative reforms. The reforms obtained in 1986 and 1987 have already shown an effect by reducing the frequency of claims. However, it appears that the frequency of claims has leveled off in 1989 and it is not possible to say what the trend will show in 1990. Early indications during the first quarter of the year, however, indicate that there will not be the need for a rate increase during 1990.

MAG Mutual continues to cosponsor with MAG very popular and successful loss prevention seminars. Seminars in 1990 will give credit to certain members of the profession who have not received credits previously and the new seminars will allow an additional discount for physicians who attended a seminar prior to January 1, 1987.

The Physician Claims Committee continues to be very effective. Data will be furnished under the financial statement at the end of the report. The contribution of the physicians who serve on the Claims Committee are invaluable in helping with the defense and management of claims.

MAG Mutual insured its first two hospitals in 1989-1990. Newnan Hospital and the Phoebe Putney Hospital in Albany, Georgia, were insured. In addition, St. Mary's in Athens has agreed verbally to accept MAG Mutual's proposal for its insurance. These are strong hospitals and excellent hospitals on which to build a foundation. We are able to enter the hospital market because of strong support from our London reinsurers who give us backing should there be any unexpected or isolated major losses. With strong reinsurance support, it is not felt that MAG Mutual is taking any significant or imprudent risks in entering the hospital market.

Also in 1989 we implemented reporting endorsement protection for physician groups carrying separate limits for the corporation, even when a physician leaving the group does not choose to purchase an individual reporting endorsement. This will protect the corporation's assets notwithstanding the decision of the individual physician who is leaving not to purchase a reporting endorsement. MAG Mutual has begun providing professional liability coverage to free-standing outpatient health care facilities such as imaging centers, laboratories, dialysis centers and outpatient surgical centers. In addition, we began to offer our "med-flex" policy to emergency rooms and similar groups to cover the corporate liability of employed or contract physicians who work only part-time. They are able to buy coverage for this part-time work without the cost of a full mature premium.

We obtained the endorsement of the Medical Association of Georgia and the Georgia Academy of Family Physicians for both MAG Mutual and its agency. The agency markets have improved substantially because of this endorsement. Life, health and disability markets have opened up to the agency and we expect considerable growth in the sale of agency products. Already growth is significant. It is a natural offshoot of the direct writing physician company to offer other agency products. We can put together a package to encompass all of a physician's insurance needs. A commission is earned on the sale of these products and will be used to offset some of the costs which are included in the price of premiums for liability insurance. We hope that physicians will inquire as to what protection is available through the MAG Mutual Insurance Agency.

In 1989 MAG Mutual improved its financial strength significantly. Its assets, its invested funds, its surplus, and its expense ratio all remained under very good control. In a market where there are declining interest rates, MAG Mutual was able to maintain its investment income at 8.1% despite the fact we have never invested in common stocks or high yield junk bonds.

The clear and dramatic growth and progress of MAG Mutual are the result of a "team effort." Organized medical groups, individual physicians, and the dedicated physicians who are involved in management of the company all have contributed significantly. Physicians set management policy, give advice and bring to the company suggestions from other physicians as to their liability insurance needs. However, the day-to-day operations are handled by a very professional and expert group of experienced executives and personnel.

A great deal has been accomplished between June, 1982 and April, 1990. The vision of the Medical Association of Georgia in sponsoring and encouraging such a physician owned and operated

company has proven to be clear. Very few, if any, physician owned companies in the United States have made the progress that MAG Mutual has made in the last several years. We continue to solicit the support of the physicians of Georgia because without that support none of this would have been possible.

MAG Mutual, its officers, its directors, and its staff are receptive to suggestions from all physicians. Many major improvements in the insurance of the company and enhancement of its services have come from suggestions made by its policyholder members. Please let us hear from you.

Attachment: 1

MAG Mutual Insurance Company Report to the Medical Association of Georgia 1990 Annual Session

Highlights of 1989 A Banner Year for MAG Mutual Insurance Company

1. Rate reduction of 22% on average.
2. Growth in number of physician insureds to 3,840 — more than any other company in Georgia.
3. Reduction to age 60 for retirement without charge for reporting endorsement — "tail coverage."
4. Expansion of the LEAD Program — a maximum potential credit of 20% for MAG Mutual's insureds.
5. Continuation of premium credits for new physicians, semi-retired physicians and attendees at loss prevention seminars.
6. Activation of SURF — a joint reinsurance venture to provide part of the reinsurance in order to reduce the cost of reinsurance and help to stabilize premiums.
7. Became insurer of Georgia hospitals as well as physicians.
8. Obtained sponsorship by MAG and GAPF for MAG Mutual and its agency.
9. MAG Mutual Insurance Agency introduced life, A & H, and disability income insurance products.
10. Began offering liability coverage for various outpatient facilities such as imaging centers.

Attachment: 2

- 22 percent rate reduction in 1989.
- Return of premiums when losses are less than anticipated.
- No settlement of claims without the physician's written consent.
- Tail coverage at no additional cost at age 60 when insured with MAG Mutual five or more consecutive years immediately preceding retirement.
- No tail coverage costs are reduction of classification at age 60.
- Option to repay tail coverage while still practicing and earning money.
- Innovative discount programs for groups, new doctors, semi-retirement, loss prevention seminar attendance.
- LEAD — Loss Excellence Appreciation Discount recognizes excellent loss experience with premium discounts which grow annually to a maximum of 20 percent as the physician remains loss-free and insured with MAG Mutual.
- Substantial premium discounts for anesthesiologists who participate in an insurance program (currently under development for obstetricians).
- Selection of policyholders based upon the medical judgment of qualified peers.
- Physician Claims Committee to review and analyze cases to advise staff and attorneys regarding the medical aspects of claims.

MAG Mutual Insurance Company Financial Results

	12/31/87	*12/31/88*	*12/31/89*
Written Premium	$55 Mil	$70 Mil	$72 Mil
Policyholders	3,344	3,664	3,840
Operating Expense Ratio	7.7%	7.8%	7.8%
Policyholders' Surplus	$10.7 Mil	$15.3 Mil	$20.8 Mil
Total Admitted Assets	$111 Mil	$148 Mil	$193 Mil
Invested Assets	$94 Mil	$126 Mil	$173 Mil
Rate of Return on Investments	8.2%	8.4%	8.1%

CLAIMS REPORT

Since Inception	*12/31/88*	*12/31/89*	*2/28/90*
Total Claims Reported	2,860	3,350	3,480
Total Claims Closed	1,997	2,518	2,603
Total Claims Open at Year-End	902	880	928
Total Claims Closed With Indemnity Payment	268	368	386
Total Claim Payments (Loss and LAE)	$50.4 Mil	$72.6 Mil	$75.8 Mil

March 30, 1990

- Legislative and tort reform efforts, unique among medical liability insurance companies.
- Restrictive underwriting, insurance guidelines and educational programs to improve the quality of medical care provided in Georgia.
- Loss Prevention programs with premium discounts to help prevent claims from occurring.
- Extremely low expense ratio, less than half that of commercial insurance companies.
- Participation in a joint-venture reinsurance company formed with physician-owned companies in Alabama, North Carolina and Kentucky.

Attachment: 4

Claims January 1-December 31, 1989 1989 Year End Report

1. Files opened in 1989: 490; Total Since Inception: 3350.
2. Files closed in 1989: 521; Total Since Inception: 2518.
3. Loss Payments in 1989, (including loss adjustment expense); $22,215,073.
4. Lawsuits Received in 1989: 107.
5. Number of Trials in 1989: 19; Wins: 16; Lost: 3. Trials Since Inception: 95; Wins: 75; Lost: 19.
6. Percentage of Cases Won: Current Year, 84%; Since Inception, 79%.

Attachment: 5

1990 Loss Prevention Seminar Schedule

Risk Prevention Skills

Date	*Time*	*Location*
April 3	5:30-9:30 p.m.	Atlanta
April 5	5:30-9:30 p.m.	Gainesville
April 11	5:30-9:30 p.m.	Columbus
April 12	5:30-9:30 p.m.	Macon
April 25	5:30-9:30 p.m.	Callaway Gardens
June 20	1:30-5:30 p.m.	St. Simon's Island
September 20	5:30-9:30 p.m.	Dalton
September 26	5:30-9:30 p.m.	Marietta
October 4	5:30-9:30 p.m.	Augusta
October 18	5:30-9:30 p.m.	Savannah
October 25	5:30-9:30 p.m.	Atlanta
November 1	5:30-9:30 p.m.	Atlanta
November 8	5:30-9:30 p.m.	Albany

Specialty Seminars

Anesthesiology		
August 24	5:30-9:30 p.m.	Sea Island
June 7	8:30a.m.-12:30 p.m.	Atlanta
Internal Medicine		
May 10	8:30 a.m.-12:30 p.m.	Atlanta
September 20	8:30 a.m.-12:30 p.m.	Callaway Gardens
Obstetrics		
May 11	8:30 a.m.-12:30 p.m.	Atlanta
September 22	8:30 a.m.-12:30 p.m.	Sea Island
Radiology		
May 18	12:30-5:30 p.m.	Hilton Head
October 11	8:30 a.m.-12:30 p.m.	Atlanta
Surgery		
June 7	8:30 a.m.-12:30 p.m.	Atlanta
September 19	8:30 a.m.-12:30 p.m.	Sea Island
Family Practice		
September 22	8:30 a.m.-12:30 p.m.	St. Simon's Island
September 29	12:30-5:30 p.m.	Macon

Office Assistants' Seminars

Date	*Time*	*Location*
April 3	12:30-4:30 p.m.	Atlanta
April 5	12:30-4:30 p.m.	Gainesville
April 11	12:30-4:30 p.m.	Columbus
April 12	12:30-4:30 p.m.	Macon
June 20	8:30 a.m.-12:30 p.m.	St. Simon's Island
September 12	12:30-4:30 p.m.	Dalton
September 26	12:30-4:30 p.m.	Marietta
October 4	8:30 a.m.-12:30 p.m.	Augusta
October 18	8:30 a.m.-12:30 p.m.	Savannah
October 25	12:30-4:30 p.m.	Atlanta
November 1	12:30-4:30 p.m.	Atlanta
November 8	12:30-4:30 p.m.	Albany

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Charles R. Underwood, M.D., Editor

We are happy to report to you that your *Journal* continues in a stable and vigorous state of health. Our Editorial Board, and you should become familiar with its members, is intact and each individual on that Board participates actively in the production of the *Journal*. We are a diverse group both from the standpoint of specialty practice and geographic location. Our "Washington Correspondent," Dr. Louis Sullivan, although understandably occupied with his duties at the federal level, nonetheless remains in our midst. This past year has been a good one for us from several standpoints.

Resolutions presented to and passed by the House of Delegates at the 1989 Session have led us into a year of fiscal stability. The present designation of twenty dollars per year from each member's dues paid represents a fair consideration of the value of the *Journal* and promotes a reasonable budgetary allocation. The additional 1989 Session resolution to modify the Roster will in 1990 result in the production of a Membership Roster that we believe will be of significant increased value to the membership. You will find it a greatly enhanced publication both from the standpoint of visual and artistic presentation as well as utility.

We continue to pursue ever more productive avenues designed to increase our advertising revenue. This past year saw significant changes in our advertising source, the State Medical Journal Advertising Bureau. We anticipate major improvements in national advertising income in the years ahead. Additional efforts aimed at increasing local advertising revenue are also underway and beginning to show promise.

The Heart Page, a long time significant feature of the *Journal*, has been for several years developed by Wesley Covitz, M.D., a pediatric cardiologist at the Medical College of Georgia. With the move of Dr. Covitz to Bowman Gray, we have been fortunate in securing the acceptance of Robert Schlant, M.D. as our new Heart Page Editor. Dr. Schlant is Professor of Medicine, Cardiology, at Emory University School of Medicine and possesses outstanding academic credentials. He has already begun his work with us. You can confidently expect a continuation of and improvement in the high quality of the material published on the Heart Page in the future.

We continue then in our efforts to produce a *Journal* that is interesting to the membership, useful from the standpoint of bringing to you scientific and socioeconomic matters which enhance your lives and your practice as well as a publication perceived by the membership of the organization as one which enhances the perception of the Medical Association of Georgia as an organization worthy of the trust and respect of every physician in the state of Georgia.

(L) Carson ("Bucky") Burgstiner, M.D., and Jane Jennings, M.D., delegates from Savannah.

C. Emory Bohler, M.D., of Brooklet, MAG's delegate to the AMA.

REPORT OF THE AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. Grace Walden, President, A-MAG (Mrs. Charles W. Walden)

Organization

There are thirty-three county medical auxiliaries in Georgia including one newly-reorganized auxiliary: Flint River Auxiliary. These thirty-three auxiliaries are as follows: Baldwin, Bibb, Carroll-Haralson, Cobb, Colquitt, Crawford Long, DeKalb, Dougherty, Flint River, Floyd-Polk-Chatooga, Franklin, Georgia Medical, Glynn, Gwinnett-Forsyth, Hall, Jackson-Banks, Laurens, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Ogeechee River, Peachbelt, Randolph-Stewart-Terrell, Richmond, South Georgia, Sumter, Thomas Area, Tift, Upson, Walker-Catoosa-Dade, Ware, Wayne, Whitfield-Murray.

Directed by: MAG Committee on the Auxiliary

Charles W. Walden, M.D.; Chairman; William C. Tippins, M.D.; Roy W. Vandiver, M.D.; Ralph A. Tillman, M.D.; Robert S. Hill, M.D.; Joe L. Nettles, M.D.; Jeffrey T. Nugent, M.D.

MAG Committees

Twenty-three (23) auxilians serve on MAG committees.

Membership

To date: March 26, 1990: 2,672 members.

Auxiliary Executive Board

The Executive Board of the Auxiliary to MAG is composed of nine (9) elected and two (2) appointed officers, all past state presidents, county presidents and county presidents-elect, and current chairmen of standing and special committees.

State Meetings

Post Convention Executive Board Meeting, Hyatt-Ravinia Hotel, Atlanta, Georgia, May 6, 1989

The President called the meeting to order, announced her theme for the year: "Proud To Be Auxilians," and presented members of the Executive Board with pins for the year. Guests at this meeting who were introduced included: personal guests of the President, members of the MAG Committee on Auxiliary, and past presidents of A-MAG. Joe L. Nettles, M.D., President of MAG, spoke briefly, followed by Mrs. Barbara Tippins, Director of the Southern Region of the AMA-A. Additional speakers were Mrs. Barbara Thibodeaux, President of Southern Medical Auxiliary, and Paul Shanor, Executive Director of MAG. Brief reports were given by officers and committee chairmen, followed by announcements and adjournment.

Summer Executive Board Meeting, Stouffer Pinelsle Resort, Lake Lanier Islands, Georgia, July 16-18, 1989

Health Projects were presented for the year. These included the areas of Safety, Non-use of Tobacco Products, O.P.A.L.S. (Older Persons with Active Lifestyles), and the Support Liaison Committees. Guest speaker was Richard A. Schieber, M.D., Director, Pediatric Critical Care Medicine, Emory University. Additional speakers were Joe L. Nettles, M.D., President of MAG, Mrs. Ruth Hardy, DeKalb auxilian; and members of the A-MAG's Legislative Team for 1989-90: Cheri Dennis, Carolyn Moon, Cherie Haun, and Wilma Tillman. Mr. Scott Ranger presented a Photography Seminar, thus concluding the meeting's impressive line-up of speakers.

MAG and A-MAG Legislative Seminar

The Auxiliary to the Medical Association of Georgia cooperated with the Medical Association of Georgia in the presentation of a legislative seminar on St. Simons Island, August 4-6, 1989. Several members of the Georgia General Assembly and their families were invited to participate in this seminar.

Winter Executive Board Meeting, Ritz-Carlton Buckhead Hotel, Atlanta, Georgia, November 17-18, 1989

This meeting was in conjunction with MAG's Scientific Assembly. The focus of this meeting was on legislation; speakers were Richard Greene, General Counsel and Director of Legislative Matters of MAG and the members of the Auxiliary's Legislative team. A financial planning seminar was presented by Mrs. Linda Harrison, a Past President of A-MAG and a Certified Public Accountant, utilizing the Auxiliary's HOW TO COPE booklet.

Annual Convention of the House of Delegates of A-MAG, Callaway Gardens Inn, Callaway Gardens, Pine Mountain, Georgia, April 26-28, 1990

Special guests were Mrs. Priscilla Gerber, A-MAA Southern Regional Vice President; Mrs. Janet Campbell, President SMAA; Mrs. Barbara Tippins, A-MAA Southern Director; and Mrs. Barbara Thibodeaux, Immediate Past President of SMAA.

AMA Auxiliary Annual Convention, The Drake Hotel, Chicago, Illinois, June 18-21, 1989

Nine (9) delegates, plus two (2) AMA-A representatives and the Southern Medical Auxiliary President attended, all of whom were from Georgia.

Southern Medical Association Auxiliary's "A Day to Remember", August 1, 1989, Winder, Georgia

Attended by the State President and a number of Georgia auxilians. A bronze placque was placed on the courthouse lawn in Winder, Georgia to honor Mrs. Charles B. Almond, founder of Doctors' Day.

AMA-A Leadership Confluence I, Chicago, Illinois, September 24-26, 1989

Attended by five (5) County Presidents-Elect and the State President-Elect.

Southern Medical Association Auxiliary Annual Convention, Washington, D.C., November 5-8, 1989

Attended by the State President, State President-Elect, and other auxilians from Georgia, to honor the Southern Medical Auxiliary President, Barbara Thibodeaux, from Marietta, Georgia.

AMA-A Leadership Confluence II, The Drake Hotel, Chicago, Illinois, February 4-6, 1990

Attended by the State President, the State President-Elect, and seven (7) County Presidents-Elect.

County Meetings

The A-MAG President visited the following county auxiliaries: Carroll-Haralson, Cobb, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk-Chattooga, Georgia Medical, Glynn, Gwinnett-Forsyth, Hall, Laurens, Medical Association of Atlanta, Muscogee, Ogeechee River, Peachbelt, Richmond, South Georgia, Sumter, Thomas Area, Tift, Walker-Catoosa-Dade, Ware, and Whitfield-Murray.

At each county meeting, the State President related the projects encouraged by the State this year, as well as encouraged the counties to participate as much as possible in State activities.

Publications

Pulse Line: four (4) issues mailed to all auxiliary members.

Auxiliary Directory: copy mailed to each member.

Annual Report: copies mailed to all Executive Board members.

Auxiliary Issue of MAG Journal: copy mailed to all auxilians across the state.

Projects and Programs

The Auxiliary emphasized four (4) main areas in health projects this year: 1. Safety; 2. O.P.A.L.S. (Older Persons with Active Lifestyles); 3. Non-use of Tobacco Products; and 4. Formation of Support Liaison Groups in local auxiliaries in the areas of Addiction Prevention Support, Surviving Spouse Support, and Malpractice Support Group. County auxiliaries were also encouraged to have Teen Health Forums in their local counties; five (5) have done this. They applied and were granted financial assistance from MAG.

The Auxiliary, with assistance from MAG, organized and presented a special "Legislative Event: in Macon, Georgia, this year; this involved a tour of historical homes and lunch — all at the request of the Legislative Wives' group, who were our guests. The Auxiliary also staffed its nationally-famous PHONE BANK during the Legislative session this year; encouraged physicians to participate in the PIP program; sent greeting cards to legislators as appropriate; and communicated with legislators on matters affecting medicine when appropriate.

In the area of membership, the Auxiliary set a record in this category for 1989-90, with over 2600 federated members (AMA, A-MAG, and local).

The Auxiliary made great strides in AMA-ERF this year, contributing more than $40,000 as of March 30, 1990. Fundraisers were held locally and statewide, as well as contributions to this worthwhile cause being made by physicians.

The William R. Dancy, M.D. Student Loan Fund was operable this year and loans were made to three students.

Visits to the Crawford W. Long Museum in Jefferson, Georgia, were encouraged.

Doctors' Day, March 30, was observed throughout the state of Georgia this year by the local auxiliaries.

Summary

This has been a most successful year for the Auxiliary to the Medical Association of Georgia: it has truly been a TEAM effort by all Auxilians!

The Auxiliary wishes to express sincere appreciation to the Medical Association of Georgia and its staff for all their assistance during the

year 1989-90. The Auxiliary particularly wants to thank Mrs. Talitha Russell, Executive Director of A-MAG, for all her guidance and assistance during the past year. The cooperation of the Medical Association of Georgia has made our work a pleasure; and we are indeed "Proud to Be Auxilians!"

GEORGIA MEDICAL CARE FOUNDATION

Joseph M. Almand, Jr., M.D., President

This coming October, 1990, is the twentieth anniversary of the incorporation of Georgia Medical Care Foundation (GMCF) by the Medical Association of Georgia (MAG). In those twenty years we have witnessed an enormous evolution in the area of health care utilization and quality review. This past year has been very significant in the changing environment in Georgia. April 1, 1989, was the starting date for GMCF's third contract to serve as the Professional Review Organization under the Peer Review Improvement Act of 1982 as amended by the Budget Reconciliation Acts of each subsequent year. The current PRO contract is different in several ways.

The number of Medicare hospital admissions selected for review has been reduced substantially. Currently, about 15% of Medicare hospital admissions are being reviewed. The Medicare review has been expanded to the Ambulatory Surgical Centers and hospital outpatient departments where the level of review is about 1500 cases annually. Quality Assurance Review for Medicare patients served by Home Health Agencies and Skilled Nursing Facilities was also added. There is no physician office review in this contract, which covers from April 1, 1989 to April 1, 1992.

We recommend for your reading three articles published in the MAG *Journal* in August, September and October, 1989, which describe the activities of the PRO in detail. The Quality Intervention Plan detailed therein is now mandated for all PRO's nationwide.

The PRO also reviews CHAMPUS admissions to hospitals in Georgia. This review is estimated to be 2000 cases per year. GMCF will also continue to review Medicare beneficiary care in Risk Contract HMO's. There are currently three HMO's that are qualified but only one has any Medicare enrollees.

On March 1, 1990, GMCF initiated a Hospital Preadmission Program for Medicaid. This contract was awarded over five national for-profit corporations. Although the length of time between the awarding of the contract and the initiation of review was short, the Board of Directors pursued the Medicaid contract because of the prospect of another private utilization review company taking over a major review contract in the state.

Another important event was the decision to resolicit members. The membership campaign resulted in almost 2,000 sign-ups. The number of members volunteering for review or committee participation is about 800. This tremendous response, especially the number of reviewers, puts GMCF in a position to provide true physician peer review. Those companies with a small number of physician reviewers are only paying lip service to the peer review concept. We know from years of experience that to provide peer review by actively practicing physicians according to medical specialty and other factors (e.g. urban vs. rural, Medicare vs. private) you must have a large number.

Admittedly the system has its imperfections, as does any review system primarily relying on retrospective chart review. To compensate to some degree, our quality intervention plan calls for multiple levels of review involving numerous physicians to assess the quality of care questions. Our goal as an organization is to have concerned professionals participating in the process and willing to render fair, impartial and unbiased decisions while cognizant of the practicing physician's situation in each case. Those of you who would like to participate with us need only call 1-800-282-2614 and request a membership package. Support physician-run, physician-sponsored review programs by joining as a member. Your membership adds strength to our organization. Please consider joining and encourage others to do so.

For seventeen years or more GMCF has been involved in the review of nursing home Medicaid patients. Federal law will change that system at the end of 1990. Instead of a team of a nurse, a social worker and a physician from GMCF, in the future nursing home review will be the responsibility of the Georgia Department of Human Resources, Office of Regulatory Services, Standards and License Division. The physicians involved in the nursing home review feel that GMCF's program has served the nursing home residents of Georgia well. It has been one area where private practicing physicians have joined with a government program in a joint effort to assure quality of care and quality of life for some 28,000 state-supported nursing home residents.

In closing, the leadership of the GMCF wish to thank the officers, Board of Directors, and staff of MAG for their support. Without that support, physician-sponsored review is not possible. With that support, we are prepared to face the challenges of the future.

COMMITTEE ON AUXILIARY

Charles W. Walden, M.D., Chairman

Committee Members

Charles W. Walden, M.D.; William C. Tippins, Jr., M.D.; Roy W. Vandiver, M.D.; Ralph A. Tillman, M.D.; Robert S. Hill, M.D.; Joe L. Nettles, M.D.; Jeffrey T. Nugent, M.D.

The first meeting of the 1989-90 Committee on Auxiliary was held at the Hyatt Ravinia Hotel on May 6, 1989. At this time, the Committee heard the proposed plans of the Auxiliary for the ensuing year, beginning with the President and extending through the other officers and committees of Auxiliary.

The second scheduled meeting of the Committee on Auxiliary was Saturday, July 15, 1989; this meeting was canceled due to lack of a quorum. The President of the Auxiliary then wrote a letter to all members of the Committee on Auxiliary detailing the Auxiliary's plans for 1989-90 and asked the Committee to approve or disapprove the plans as outlined. The response was overwhelmingly in favor of the Auxiliary's plans as presented.

The last scheduled meeting of this Committee will be at the Annual convention at Callaway Gardens on Friday, April 27, 1990.

CONTINUING MEDICAL EDUCATION COMMITTEE

Hillary R. Newland, M.D., Chairman

Our Committee continues to promote continuing medical education across the state.

Mandatory CME

The big news this year was the passage of a mandatory CME law.

The 1988 MAG House voted to oppose our drafting such a bill. Therefore, last year the Georgia Academy of Family Physicians was principal sponsor of a bill, HB 702, which likely would have passed in 1989 had not a Senator added an amendment for mandatory assignment.

The bill, minus the mandatory assignment language (of course), was successfully handled by family physician Rep. George Green during this past session of the General Assembly. Basically, it calls for 40 hours of CME during the two-year relicensure period, and gives the Composite State Board of Medical Examiners authority for implementation. The bill was passed by the House on February 26, by the Senate February 28, and has been signed by the Governor.

Our Committee has discussed the new law, and is awaiting the guidelines for implementation, as drawn up by the Composite State Board of Medical Examiners.

MAG Statement on CME

Back in 1979 our House of Delegates adopted a formal "Medical Association of Georgia Statement on Continuing Medical Education" in which we stated our opposition to mandatory CME for relicensure. Three years ago, at the direction of the House, we deleted this statement of opposition. Now that a mandatory CME law has been enacted, we think further modification of our Statement is called for.

Our Committee therefore will be working on a revision of MAG's statement, and will eventually bring it before the Board of Directors.

Our Ongoing Work: Accreditation

Aside from planning activity on the above issues, we've been busy advising and accrediting Georgia organizations and institutions which provide continuing medical education. (Accredited status allows the CME provider to authorize Category 1 AMA credit for appropriate educational activities.) In 1989 we conducted the initial accreditation survey of two hospitals and resurveyed seven more hospitals or specialty societies, extending their period of accreditation based on their ability to meet the ACCME *Essentials* for Category 1 continuing medical education.

As of this writing, seventeen medical organizations and twenty-three hospitals are accredited for CME by MAG. These 39 providers are:

American Academy of Pediatrics — Georgia Chapter
American Cancer Society — Georgia Division
American Heart Association — Georgia Affiliate
Athens Regional Medical Center
Atlanta Society of Pathologists
Augusta Obstetrical & Gynecological Society
Cobb Hospital and Medical Center
DeKalb Medical Center
Georgia Academy of Family Physicians
Georgia Academy of Family Physicians — Educational Foundation
Georgia Baptist Medical Center, Atlanta
Georgia Gastroenterologic Society
Georgia Orthopaedic Society
Georgia Psychiatric Physicians Association
Georgia Radiological Society
Georgia Psychiatric Physicians Association
Georgia Radiological Society
Georgia Rheumatism Society
Georgia Society of Anesthesiologists
Georgia Society of Ophthalmology
Georgia Surgical Society
Glynn-Brunswick Memorial Hospital
Greater Atlanta Otolaryngology — Head & Neck Surgery Society

Hamilton Medical Center, Dalton
Hughston Sports Medicine Foundation, Columbus
John D. Archbold Memorial Hospital, Thomasville
Kennestone Hospital, Marietta
The Medical Center, Columbus
Medical Center of Central Georgia, Macon
Memorial Medical Center, Savannah
Northeast Georgia Medical Center, Gainesville
Northside Hospital, Atlanta
Phoebe Putney Memorial Hospital, Albany
Piedmont Hospital, Atlanta
Ridgeview Institute, Atlanta
Scottish Rite Hospital, Atlanta
South Georgia Medical Center, Valdosta
St. Joseph's Hospital, Atlanta
Sumter Regional Hospital, Americus
University Hospital, Augusta
Vinson VA Medical Center, Dublin
West Paces Ferry Hospital, Atlanta

During the past year, Committee members and staff have also held consultations with several institutions expressing interest in becoming accredited. We perceive that some of this interest reflects recent state legislative activity on mandatory CME.

Joint Sponsorship

From time to time our Committee is asked by various unaccredited CME providers to authorize AMA Category 1 credit for their educational meetings. Reflecting the national guidelines for CME (the *Essentials* of the Accreditation Council for Continuing Medical Education), we will authorize no Category 1 credit for a medical meeting unless we have been given the opportunity to participate in program planning. Whenever feasible, we defer an applicant for joint sponsorship to another accredited intrastate provider — such as the pertinent specialty society or a local hospital.

In the past year (since June 1, 1989), we have received a number of requests for cosponsorship, and have agreed to jointly sponsor the following activities:

1. Smyrna Hospital YAG Laser Workshop, Nov. 20, 1989 (3.5 credit hours)
2. Georgia Hospital Association Teleconference (1 credit hour each): Panic & Anxiety Disorders, June 15, 1989; Clinical Anxiety in Cardiovascular Patients, June 31, 1989; Falls in the Elderly, July 26, 1989; Cancer Related Pain, Aug. 30, 1989; Sleep-Wake Disorders, Sept. 21, 1989; Thrombolytic Therapy — Acute Myocardial Infarction, Sept. 27, 1989; The Brain, Stress, and High Blood Pressure, Oct. 18, 1989.
3. MAG Mutual Insurance Company - Good Practice Policy Introductory Seminar (3.5 credit hours each): June 12, 1989 — Albany; June 24 — Albany; October 26 — Atlanta; November 8 — Macon; November 29 — Gainesville; November 30 — Rome; December 6 — Augusta; December 7 — Valdosta.
4. MAG Mutual Insurance Company Good Practice Specialty Seminar (3.5 credit hours each): Psychiatrists — November 16 — Atlanta; Emergency Physicians — November 16 — Atlanta.

National Reaccreditation of MAG

As noted above, the Medical Association of Georgia is accredited by the national Accreditation Council for Continuing Medical Education as a provider of CME — meaning that MAG has the capacity to issue AMA Category 1 credit for scientific conferences, risk management seminars, or other courses so designated by us for credit.

We received this accrediation by ACCME back in February, 1984 for a period of six years. MAG therefore came up for an accreditation resurvey earlier this year.

It was, frankly, a big deal. Just the resurvey fee alone was $1600 — our thanks once more to go the MAG Board of Directors for allocating the money last October. Then we had to prepare the MAG's reaccreditation application, which resulted in a 218-page document, printed in triplicate and sent up to Chicago three weeks before our inspection date. Finally, on February 9, 1 and our Committee staff flew up to Chicago for an hour's questioning by five ACCME resurveyors.

I'm pleased to say we passed inspection. On March 5 ACCME notified us that it had approved reaccreditation of the Medical Association of Georgia for four years.

MAG Program for Clinical Excellence

Last year MAG's Board of Directors called on us to develop, in conjunction with the Georgia Medical Care Foundation and the Composite State Board of Medical Examiners, a plan to assist physicians in finding the individualized continuing medical education they may need to comply with peer review or hospital quality assurance findings.

Other states are doing this. Florida, for example, is setting up a "Program for Clinical Excellence," which would assist not just sanctioned doctors, but any physician who seeks to gain some special skill or body of knowledge for improved competence.

Because we feel that medical school involvement is necessary, I presented my ideas to the deans of Georgia's four medical schools last October. All were receptive, and since then we've been in touch again with the deans, ascertaining more specific responses. We'll continue to report our progress.

* * *

I wish to conclude by thanking the members of the Committee — talented and hard-working individuals, every one:

William C. Allsbrook, M.D.; John R. Broshears, M.D.; John L. Davis, III, M.D.; Joseph M. DeGross, M.D.; John A. Hudson, M.D.; Carlton D. Lancaster, Jr., M.D.; James S. Maughon, M.D.; Neil G. Perkinson, M.D.; Alan Plummer, M.D.; Carl L. Rosengart, M.D.; Robert C. Schlant, M.D.; George W. Shannon, M.D.; William E. Silver, M.D.; Rodney L. Smith, M.D.; Roland S. Summers, M.D.; Charles R. Underwood, M.D.; William H. Whaley, M.D.; Robert C. Fore, Ed.D. (Consultant).

James A. Kaufmann, M.D., (Center) Speaker of the House of Delegates, focuses momentarily on the camera while MAG's General Counsel, Richard A. Greene, explains a legal point in digital detail to Michael Roberts, M.D., a delegate from Albany.

MATERNAL AND INFANT HEALTH COMMITTEE

Luella Klein, M.D., Chairman

The Maternal & Infant Health Committee considered the following issues this year:

1. ongoing problems with the delivery of care through the Georgia Regional Perinatal System;
2. pending Georgia legislation relating to maternal and infant health;
3. abortion issues;
4. Georgia Maternal & Infant Health Council Recommendations to Improve Health of Georgia's Mothers and Babies; and
5. proposed rules for Medicare Coverage of Screening Mammography.

1. Georgia Regional Perinatal System.

Although problems continue, there is some hope that funds will be increased. The number of disproportionate share hospitals have increased; and efforts are underway to establish a tertiary center in Albany and perhaps one in South Georgia.

2. Pending Georgia Legislation.

SB 553: Arbitration in medical malpractice claims involving obstetrics, anesthesiology pediatrics and neonatology. The Committee strongly supported MAG's efforts to deal with the crisis in delivery of obstetrical care in Georgia.

The Committee further endorsed MAG's stated position on:

HB 999 — Durable Power of Attorney for Health Care Decisions.
HB 1040 — Child Health Service Act.
HB 1135 — Expert Witness.
SB 289 — Attack on Collateral Source.

3. Abortion issues.

The Committee reviewed MAG's current policy statement (adopted in 1983) and a number of media articles reflecting the ongoing conflict between the "pro life" and "pro abortion" elements, as well as changing stage legislative activities and court actions.

The Committee members felt that there is a generally unrecognized distinction between a "pro choice" stance, which leaves the decision making to the patient and the physician, and that of "pro abortion" advocates for abortion on demand. It also realizes that some elements

of the current MAG position statement do not reflect current realities; however, the Committee felt that it would be inappropriate to make any changes in MAG's statement at this time since any overt MAG action could result in divisive political turmoil.

4. *Maternal & Infant Health Council.*

The Committee heard a report on the Maternal & Infant Council's concerns about the decreasing availability of physicians to provide obstetrical care. At the time of this report there were 74 counties without obstetrical delivery care from any source.

5. *Medicare Coverage of Screening Mammography.*

The Committee reviewed HCFA's September 1, 1989 proposed rules relating to Medicare coverage for mammograms. There were concerns that the allowable fee of $50.00 would limit the testing to screening only and perhaps not allow more definitive procedures but the Committee did not recommend that MAG file a response to this proposal.

The Committee received further information relating to:

- Right From the Start — expanded Medicaid Eligibility for Pregnant Women and Children (increased eligibility ceiling from Georgia 40% of poverty level to 100% — note: more recent federal legislation has now increased this to 133% of the poverty level.)
- Department of Medical Assistance (Medicaid) expansion of Family Planning services.
- Proposed Georgia Department of Human Resources Rules entitled "Serologic Test for Syphilis for Pregnant Women."

Georgia Mortality Vital Statistics Report
(1988 date published November 1989)

As customary, the Committee submits for your information the following excerpt from the Georgia Department of Human Resources, Vital Statistics Department.

	Number			Rate*		
Item	**Total**	**White**	**Black**	**Total**	**White**	**Black**
Live Births	105847	67186	37166	16.7	14.5	21.8
Age of Mother						
10-14	525	94	427	2.0	0.5	4.9
15-17	6554	2934	3593	37.2	24.7	63.0
18-19	10202	5544	4613	85.4	68.6	119.0
Unwed Mother Birth Rate	31378	8237	23012	20.5	7.5	53.1
Age of Mother						
10-14	493	65	426	1.8	0.4	4.9
15-17	4845	1341	3493	27.5	11.3	61.2
18-19	5796	1719	4065	48.5	21.3	104.9
% Birth Weight grams						
<500	215	67	146	0.2	0.1	0.4
500-1499	1502	635	862	1.4	0.9	2.3
1500-2499	7166	3379	3690	6.8	5.0	9.9
Spontaneous Abortion Rate	6792	4292	2396	4.4	3.9	5.5
Age of Mother						
10-14	29	9	20	0.1	0.0	0.2
15-17	381	200	178	2.2	1.7	3.1
18-19	556	324	226	4.7	4.0	5.8
Induced Termination Rate	32068	17017	14145	20.9	15.5	32.7
10-14	316	86	226	1.2	0.5	2.6
15-17	3316	1842	1422	18.8	15.5	24.9
18-19	4415	2606	1735	36.9	32.3	44.8
Total Deaths	51593	36890	14568	8.1	8.0	8.5
Lifestages						
Infancy (<1)	1342	613	723	12.7	9.1	19.5
Neonatal	893	393	494	8.4	5.8	13.3
Post-Neonatal	449	220	229	4.2	3.3	6.3

*Rate per 1,000 except % Birth Weight which is per 100 in weight group.

MEMBERSHIP EXPANSION & INVOLVEMENT COMMITTEE

Roy W. Vandiver, M.D., Chairman

The Committee met in October, 1989.

In conformity with an action of the MAG Executive Committee regarding Committee structure and reorganization, it is planned to pare the size of the Committee down to five to seven members following this year's elections.

New Membership Materials

In conjunction with the Division of Communications and MAG Mutual Insurance Company, we have developed a professional recruitment tri-pocket packet for inclusion of materials from the component county medical societies, MAG and MAG Mutual, with slots for business cards/contacts from each organization. In the inner brochure, "The ABC's of MAG," information on some of MAG's functions and programs is described. Stationery was designed to compliment the other materials, and it is available to the county societies for personalized letters relating pertinent local level information.

A new student brochure and a new young physician pamphlet were printed and distributed in early 1990. The student, resident and regular membership applications were redesigned and reprinted to conform with the graphics of the materials mentioned above.

A new resident brochure is being planned for production during the summer of 1990. In addition, we plan a county medical society officer's guidebook, which would be distributed to all societies, outlining a county society's duties, services, etc.

All these materials are intended for use over a three year period by MAG, MAG Mutual and the component county medical societies, and the Committee would like to especially commend Dr. Joy Maxey and Ms. Priscilla Daves for their able and enthusiastic work with the membership staff in helping us prepare all our new membership materials.

Recruitment Projects

During the past year, the Committee has conducted several special recruitment programs, resulting in attractive membership gains and income:

Specialty Society Membership and Recruitment to MAG

Membership lists of Georgia specialty societies were obtained and compared to information on file at MAG. Printouts by specialty were forwarded to specialty society members of the MAG Membership Expansion and Involvement Committee for their assistance in recruiting MAG members within their particular specialties. Specialty society membership indicators were added to MAG's data bank in October.

Medical Student Outreach Program

The AMA Division of Membership awarded several medical student members monies totaling over $3,500.00 for recruiting AMA student members during 1989. These funds will be used to pay for expenses incurred by the students attending the Interim and Annual AMA meetings.

Resident Member Recruitment

We received 42 new applications from the entire new student class at Mercer University School of Medicine.

Young Physician Section Recruitment

At the direction of Dr. Joy Maxey, a recruitment program targeted directly at young physicians (under 40 years of age or in practice less than five years) was initiated.

Data tapes were received from the Composite State Board of Medical Examiners and from the American Medical Association, listing physicians in this category in Georgia. The information was compared to data already on MAG's computer, and a listing was produced which excludes those who are already MAG members.

In January, 3,500 recruitment packets were sent which included personal letters from Dr. Maxey. After initial mail returns and bad addresses were removed/updated, it was determined that there are 2,536 potential young physician members.

Initial results: 6 or .20% Have applied; 6 or .20% Have applied, with applications approved by county societies; 13 or .43% Have applied, with applications approved by county societies, and dues have been received; 7 or .23% Requested more information on MAG.

Income to date: 13 Active, $4,680.00; Projected Income*, $32,760.00.

**Based on the average membership of seven years per member and not considering possible dues rate increase(s).*

Our Division of Education is contacting those who requested more information, and Dr. Maxey intends to lead a follow-up to those who have not responded by distributing printouts to Young Physician Section representatives in each district throughout the state.

Reinstated Members

In late November, special letters inviting reinstatement of membership were sent to 703 former members who had dropped out during

1986, 1987, and/or 1988. A follow-up to this mailing and invitation was sent in March to those who had not responded or rejoined. To date, 47 active members and two residents have rejoined the Medical Association of Georgia.

Income, $16,950.00; *Projected Income,* $118,650.00.

With the delinquency date for 1990 upon us, final notices were forwarded the last week in March to 547 members whose dues have not yet been paid.

Additionally, second notices were sent to 229 members who paid county and state but no AMA dues.

State Licensure

As a service to the membership, reminders of licensure renewal are being sent to 467 physicians who have not renewed their Georgia licenses. This information was provided on data tape via the Composite State Board of Medical Examiners.

AMA Membership Incentive Award

In February, MAG received an award of $16,745.00, for increaseing AMA membership during 1989. This is the fourth category of the award, which is the highest possible dollar amount we could obtain; we met AMA's highest membership goal for Georgia in 1989.

AMA Delegate

Staff contacted AMA in February and it was determined that MAG is now entitled to a new delegate and alternate position to the AMA House of Delegates. This is a result of over 75% of MAG's members being AMA members.

AMA National Membership Symposium

Staff attended AMA's first National Membership Symposium in Chicago. We became aware of a new electronic dues reporting system available to state associations. Since November, 1989, we have been reporting our AMA dues electronically, alleviating the 30-90 day lag time at AMA for dues processing when dues were reported by hard copy.

Biographical Information for Membership Directory

As a mandate of the 1989 House of Delegates, biographical updates have been requested of all MAG members. Although 50% of the update forms were received in one month; to date, 4,843 members have complied.

Follow-up reminders to the membership asking them to forward the information were in the *MAG Newsletter* and *Journal,* and another request was mailed in March to the members who had not returned the information.

To be included in the new MAG *Directory* of the membership will be physicians' hospital affiliations and home and office addresses and telephone numbers. Additional information, such as board certifications and licensure information will be added to the system but will be available to only members and staff.

Update on Societies With Deficit Membership

As reviewed at the 1989 House of Delegates, the county societies with less than five active dues members are listed below. The information provided is as of March 26, 1990:

At its January, 1990, Board meeting, MAG deferred this item to the Board of Directors meeting which will be held in conjunction with the 1990 House meeting.

Current Membership

Total membership as of March 30, 1990 is 7225.

	Active	*Retired**	*Life*	*Total*
Henry	3	1		4
Jefferson	0	1	1	2
McDuffie	1	1		2
Randolph-Stewart-Terrell	3	2		5
Screven	0	1		1
Wilkes	3	1		4

** Retired members do not count toward a county society's required five needed to maintain a society's Charter.*

PRISON HEALTH CARE COMMITTEE

Robert H. DeJarnette, M.D., Chairman

The Prison Health Care Committee met four times in the past year under the leadership of Chairman Robert H. DeJarnette, Jr. The contract for fiscal year 1990-91 with the Georgia Department of Corrections is for a total of $48,072. For the full year preceding the date of this report, March 1, 1990, the total income from accreditation fees paid to MAG is $9,280. Most of these accreditation fees are used as consultant fees and reimbursement or

travel expenses paid to physicians who are members of this Committee. The physician members of this Committee continue to participate on all accreditation and reaccreditation site visits conducted. Funding for the project and fees are expected to remain at this level for the next year.

Georgia State prisons that have been reviewed for accreditation since the last annual report of this Committee are Montgomery Correctional Institute in Mt. Vernon; Bostick Correctional Institute at Hardwick; Metro Correctional Institute in Atlanta; Central Correctional Institute in Macon; Georgia State Prison and Rogers Correctional Institute at Reidsville; Dodge Correctional Institute at Chester; and Georgia State Women's Prison at Hardwick. All of these facilities were reaccredited by the Committee for two full years except Bostick Correctional Institute in Hardwick which is a first accreditation for one year.

Jails that were visited during the same period include Richmond County Jail in Augusta; Douglas County Jail in Douglasville; Newton County Jail in Covington; Cobb County Detention Center in Marietta; and Monroe County Jail in Forsyth.

Jail facilities were reaccredited for two years except Richmond County Jail which was not reaccredited. This facility will be revisited to monitor recommended changes when we are advised they are ready. A revisit was conducted at Randolph County Jail and they were returned to full accreditation. Taylor County Jail in Butler could not maintain accreditation level of services. They may reapply later if the situation improves.

In addition, a first accreditation site visit was conducted at the Atlanta Youth Development Center in Adamsville. Accreditation for one year was awarded in September of 1989.

FINANCIAL REPORT

INCOME		
Registration fees		$39,206.75
Exhibitors		2,250.00
Pharmaceutical Grants		1,000.00
		42,456.75
EXPENSES		
Specialty Society Reimbursements		11,615.53
Hotel		20,185.82
AV — Corporate AV		4,129.41
Signs — Freeman Company		440.16
Postage includes Society Mailing		1,407.72
Miscellaneous office		53.15
Alpha Printing		
Final Program	1,1336.86	
CME Certificates	77.92	
Registration Forms	119.62	
Hotel Cards	62.23	
		1,596.63
Badges		279.00
Typewriter		26.35
Staff Travel		55.00
CME Application ACEP		75.00
		39,863.77
SUMMARY — 1989 SCIENTIFIC ASSEMBLY		
INCOME		42,456.75
EXPENSES		39,863.77
		2,592.98

The bottom line, as you see, shows us slightly in the black — just where we want to be.

* * *

Several facilities will be entering into the accreditation program this year. Prisons expected are: Coastal Correctional Institute in Savannah with over 900 inmates; Valdosta Correctional Institute with 1000 inmates; the S.W. Probation and Detention Center in Moultrie; and the Ware County Correctional Institute in Waycross. Two small jails are expected to apply. They are the Dade County Jail in Trenton and the Bartow County Jail in Cartersville.

In late April of 1990, the Georgia Chapter of American Correctional Health Services Association will present the Sixth Annual Symposium on Correctional Health Care entitled "Succeeding and Surviving in the 90's." The conference is planned at Unicoi State Park Conference Center at Helen, Georgia.

This Committee appreciates the support given by MAG and respectfully submits this report as information on the progress experienced during the past year.

SCIENTIFIC ASSEMBLY COMMITTEE

Roland S. Summers, M.D., Chairman

Our recent Scientific Assembly, held last November 17-19, was another very good meeting.

Ten specialty societies chose to offer CME programs with us this time. Our final registration figures break down thus:

Allergy & Immunology	34
Emergency Medicine	26
Neurology	66
Neurosurgery	62
Ophthalmology	105
Orthopedics	91
Otolaryngology	63
Pathology	132
Plastic Surgery	36
Psychiatry	108
TOTAL	723

This total was up considerably from our 1988 meeting, and can be explained in a couple of ways. We had one more specialty with us this year (the Georgia Orthopaedic Society) and the superb program planned by Dr. Collins and Dr. Nugent drew in a strong attendance. Our other nine programs drew very well, too. I want to particularly thank Mrs. Walden and the Auxiliary to MAG for choosing to hold its Winter Board meeting during our weekend at the Ritz; it was a pleasure having our wives meet with us.

We also did well because the Ritz Buckhead remains a very appealing site, especially on the weekend before Thanksgiving. Finally, last November's conflict with the Georgia-Auburn game on Saturday did not, it seems, hurt our registration measurably.

* * *

Plans For This Fall

We're set once again for our 1990 Scientific Assembly, to be held once again at the Ritz-Carlton Buckhead this November 16-18. We expect to have almost all of our participating societies back with us, plus we're pleased to have several new societies planning to hold meetings with us: the Georgia Obstetrical and Gynecological Society, the Georgia Society of Internal Medicine, the Georgia Chapter, American College of Cardiology, and the Georgia Chapter, American College of Occupational Physicians.

* * *

Proposal for Disbanding Our Committee

This Committee was created some 15 years ago, after the House voted to split the MAG "Annual Session" into *two* meetings: the House of Delegates and the Scientific Assembly. Like the Annual Session Committee, Scientific Assembly was made a "Standing Committee" of the Association, specifically provided for by the MAG Bylaws.

We recommend a change in this structure. Because our Committee must formally request AMA Category 1 credit from MAG's Continuing Medical Education Committee, it seems logical to provide for a closer relationship between the MAG Scientific Assembly and CME Committees. The national CME accrediting agency has in fact called for such a merging of functions.

The Scientific Assembly and CME Committees have therefore submitted a separate resolution to the Committee on Constitution & Bylaws, calling for the disbanding of the Scientific Assembly Committee as a standing committee of MAG, and renaming of the CME Committee "Continuing Medical Education/ Scientific Assembly Committee."

Throughout the years, I've been assisted by some very capable Committee members, whom I'd like to thank now:

Edwin C. Evans, M.D.; Ellis B. Keener, M.D.; George W. Shannon, M.D.; Carter Smith, Jr., M.D.; William C. Waters, M.D.

COMMITTEE ON SPECIALTY SOCIETY RELATIONS

Ellis B. Keener, M.D., Chairman

The Committee on Specialty Society relations has not met during the past year but remains an active Committee that meets the needs of the Medical Association of Georgia's formal relationship to the various specialty societies.

The Georgia Society of Clinical Oncology has petitioned the Committee for membership and it is anticipated that this request will be dealt with at the next meeting. If approved this would bring to a total of 28 medical specialty societies that are represented on the Specialty Society Relations Committee and are hence, formally recognized by the Medical Association of Georgia. Recognition is step-one in the appointment of a representative from each specialty society to the MAG Council on Legislation.

The Committee has been informally advised that the new Georgia Chapter of the American College of Cardiology will also make appli-

cation for membership on the Specialty Society Relations Committee at the appropriate time in the future.

Membership on the Committee is by application that is carefully evaluated by the Committee pursuant to written criteria that has been approved by the MAG Board of Directors. The Board acts on the recommendation of the Committee and is the final authority on admission to the Specialty Society Relations Committee.

The steady growth in the number of specialty societies seeking admission to the Specialty Society Relations Committee is clear evidence of the vitality and emerging importance of specialties in the federation of organized medicine. They have long been recognized as leaders in the field of continuing medical education and are now beginning to apply the same focused dedication and zeal to their socioeconomic concerns. MAG needs very much to find ways to help the specialties remain in the mainstream of organized medicine and in so doing enlist their full participation as equal partners. The problems facing organized medicine will require the best efforts of everyone. No one should be left on the outside looking for a way to participate.

I want to thank all the representatives of the specialty societies for their participation and their steadfast support of and service to the Medical Association of Georgia.

PHYSICIANS DISPENSING AND DRUGS COMMITTEE

Richard A. Wherry, M.D., Chairman

Charge:

This Committee will conduct a study of both physician drug dispensing and the generic substitution of drugs.

The physician dispensing issue will be comprehensively studied including the possibility of MAG issuing policy guidelines on the ethical, management, and legal considerations facing the physician.

The controversial generic substitution of drugs will be evaluated in order to develop policy regarding generic drug substitution and to suggest possible legislative changes.

The Committee will report its findings and recommendations to the Executive Committee and to the Board of Directors.

(Authority: 1987 House Actions, Reference Committee C, Third Party Payors Committee and Resolutions #15 and #24.)

This Committee's past activities have been directed primarily toward issues relating to physician dispensing.

As it began to look more thoroughly into generic substitution of drugs, a national generic drug scandal erupted at the Food and Drug Administration with revelations of fraud in the generic drug industry. The news media has widely reported allegations and FDA responses. This drug industry war is likely to escalate. The FDA has instigated a wide spread investigation of the generic drug industry.

The American Medical Association Board of Trustees is presently drafting a report for the June 1990 meeting of the AMA House of Delegates that addresses issues relating to the controversy over generic drugs. Your Committee has received a copy of a white paper on Generic Drugs developed by the American Academy of Family Physicians.

In view of the current national situation, it was not deemed advisable to develop any specific policy recommendations at this time. The Committee expects to monitor national developments, review both the Academy of Family Physician's White Paper and the AMA actions in June 1990 and make any specific policy recommendations for Georgia to the MAG Executive Committee or Board of Directors during the upcoming fiscal year.

Second Session
House of Delegates
April 28

THE SECOND SESSION of the MAG House of Delegates was called to order at 9 a.m., Saturday, April 28, at Callaway Gardens at Pine Mountain by Speaker James A. Kaufmann, M.D.

Dr. Kaufmann asked for a report from the Credentials Committee, which confirmed that a quorum was present. Because there was only one contested race this year, the election was held early in the Second Session. Ballots were distributed prior to the keynote address given by Georgia's Secretary of State Max Cleland, who spoke at 11:30 a.m.

Georgia's Secretary of State Max Cleland was the keynote speaker for the Saturday Session. His address was humorously entertaining and seriously engaging as he discussed the role of doctors in solving health care delivery problems in the state.

Dr. Rodney Smith (R), of Gainesville, President of the Ninth District Medical Society, presents Georgia Senator Nathan Deal with a special award for the latter's support of medicine in the political arena. In the background, Vice Speaker of the House, Dr. Jack Raines, from Columbus, joins in the congratulatory applause.

Presentation of Legislators' Awards

The following legislators received special awards for their loyal support of quality medicine: Sen. Nathan Deal, Sen. J. Crawford Ware, and Rep. Tommy Chambless.

Reference Committee Reports

The reports of Reference Committees A, B, C, D, F and Constitution and Bylaws were presented in order during the day's proceedings. Full copies of these reports are printed in order elsewhere in this issue of the *Journal*.

Following the reports, the Speaker recessed the House at 4:15 p.m. with the reminder to attend the Installation Ceremony of new officers and the Presidents' Reception at 6 p.m.

Report of Reference Committee

The following physicians were members of Reference Committee A: Donald H. Campbell, Chairman, Cobb; Charles W. McDowell, Jr., Vice-Chairman, DeKalb; William A. Wolff, Muscogee; John T. Yauger, Medical Association of Atlanta; John Ed Fowler, Stephens-Rabun; E. Dan DeLoach, Georgia Medical; and Phillip K. Rhyne (Student) Bibb. MAG Staff: Joyce Butler, Director of Community Services.

OFFICE OF FIRST VICE-PRESIDENT

Bob G. Lanier, M.D.

This year has been quite an eventful one. Our President, Joe Nettles, saw fit for me to serve as Chariman of the Ad Hoc Committee on Senior Citizens Advocacy and I was also appointed to the Governor's Commission on Access to Health Care. I also had the opportunity to represent MAG as a member of the State Task Force on Community Care. This led to my considerable exposure not only to the thoughts of the physicians of MAG, but to those of our patients and the community at-large as well. A great deal of time and emotion has been expended relative to this topic — health care for the needy, young and old.

The reality of the situation is like trying to grasp a handful of Jello. For every solution sought, more pressure is applied and it is very easy to come up empty-handed with only the stain of reality in your hand.

MAG has originated the Physicians Care Program, designed to serve the citizens of Georgia who are age 65 or over, or below the 150th percentile of the national poverty level. This means that patients over age 65 who are single and earn less than $8,950 or couples who earn less than $13,425 are eligible to apply for the Physicians Care Program. There will be two categories of those patients: 1) those who are 65 and only have Medicare insurance, and 2) those who are 65 and older who have no insurance at all.

We have asked the physicians of Georgia to participate in providing access to health care for these patients. Thus far, we have too few physicians enrolled in this program and we need many more participants from our membership. I think we will get a more positive response as soon as our colleagues are educated to the necessity of this program. We are approaching this from a humanitarian point of view, but it has a practical application as well. We would like to prevent the mandating of health care for the Medicare and Medicaid recipients as a condition of medical licensure in our State. If we can demonstrate our willingness to participate and accept our portion of responsibility for the health care system, then I think that the results will be favor-

able for both the physicians and patients of the State of Georgia.

We have to go further than the present Physicians Care Program. The Physicians Care Program is only a method of gaining some experience in dealing with a humanitarian, social and political issue. We must develop a plan that will protect the freedom of our patients, hospitals, insurance companies and physicians. We must limit state and Federal government involvement as much as possible. State and Federal government involvement only leads to more bureaucratic administrative costs and controls of medical care. We have numerous examples of this plaguing us at the present time so I do not need to give you examples.

There are a few facts that should be reviewed and learned by all of us. We all wonder if the numbers are exact. Some may be, and others may be more generalizations; nevertheless, these are the figures that we have worked with. These "facts" are as follows:

1. Health expenditures in America approach 12% of the gross national product.

2. Between 31 and 37 million Americans are uninsured or under-insured.

3. Twelve million of the uninsured or under-insured are children.

4. Approximately one million Americans are denied care because of their lack of ability to pay. Some think this may be as high as 14 million, however, this number probably represents more emotion and social stigma than reality.

5. In 1980 Medicaid covered 65% of the nation's poor.

6. In 1989, because of budget cuts and tighter eligibility, Medicaid covers 38% of the nation's poor.

Donald H. Campbell, M.D, from Cobb County, chaired Reference Committee A.

7. 28% fewer people have health insurance today than in 1980.

8. Americans may want a cheaper and more equitable health care system even at the expense of reduced quality.

What are the problems facing our health care system?

1. Some leaders agree that some changes are needed.
2. No one knows what the changes should look like.
3. No one is willing to foot the bill.

Members of Reference Committee A (L to R): John T. Yauger, M.D.; Charles W. McDowell, Jr., M.D., Vice Chairman; and Donald H. Campbell, M.D., Chairman.

4. Should mandates be instituted to require individuals to carry their own health insurance?
5. Should employers be mandated to supply employees with health insurance?
6. Should the federal government provide basic health care and pick up the tab?
7. Should state and federal taxes be increased to supply funds for basic health care?
8. Is "managed care" a solution?
9. Can we maintain a fee-for-service health care system?
10. Can we maintain an indemnity insurance system?

Obviously when we try to answer these questions, there is not a single solution. If we are going to be successful, we will probably need several solutions.

We must keep in mind the fundamental need to protect those parties involved. However, like everything else in life there has to be some compromise with the present proposals put forward.

1) Mandated Benefits

a) This would require businesses to pick up a certain percentage of the health care tab for their employees.

b) Employers hate mandated benefits just like physicians hate mandated care.

c) Both express that increased costs and loss of income will force them to decrease the labor force or decrease the quality of care.

2) Health Care "Canadian-Style"

a) This is a fee-for-service system with the federal government serving as the *only third party payor.*

b) This is financed by the federal government, but administered at the state level.

c) Citizens receive plastic cards that entitle them to all medical services.

d) Physicians are salaried employees of hospitals or work on a fee-for-service basis.

e) Physicians negotiate fees with a federally appointed State regulatory board.

f) HMOs are paid fees on a per patient basis to cover all services.

g) Funding is acquired through income taxes. Increase in payments are tied to a fixed percentage of the total gross national product.

This system relies on fixing prices, bureaucratic controls, decreased use of modern technology, slow adoption of new procedures and waiting lists for routine procedures. (This rationing decreases costs.)

3) Managed Care Mix

a) Private health insurance and employee health benefits remain the same.

b) There would be guarantees of a minimum benefits package for everyone.

c) All employers would be required to offer health benefits.

d) The indigent who do not qualify for Medicare or Medicaid would be in managed programs (HMOs and PPOs),

e) Funding would come from a new tax on part-time and self-employed workers and a tax on a portion of benefits.

Obviously quality and availability of care is affected by this system, but access to health care and acute care would be enhanced. Chronic care and preventive care would be severely curtailed.

4) Fail Safe Insurance Program

a) Individual medical coverage would be mandated for all Americans.

b) Those unable to obtain insurance or pay for insurance would be enrolled in fail safe insurance programs.

c) *Free riders* would receive tax penalties if they did not obtain insurance above a certain income.

d) A managed care system (HMO/PPO) would deliver care to *this group* of individuals.

e) Income taxes, co-payments, and taxes on alcohol, tobacco and gasoline would provide funding.

5) Private Sector Plan

a) Employers would be required to negotiate with local insurance agencies to provide insurance coverage for all workers, with options for family coverage.

b) Insurance companies would be encouarged to make policies available to groups of small businesses to spread risk and reduce premiums.

c) Workers could choose whether to participate. Those choosing not to participate would remain responsible for their own medical care.

d) State, county and municipal governments would establish risk pools and request bids from private insurers to provide health insurance for the group(s) of beneficiaries they choose to cover, e.g., employees, indigents and the "uninsurable."

e) This leaves access to health care up to the individual and not to a mandated state or local government requirement.

6) Back to School Coverage

a) This applies to insuring the 10 million uninsured or under-insured children of the 31-37 million uninsured or under-insured Americans.

b) Since school age children are thought to be a better insurance risk, it appears that group policies offered through local school systems could be offered at a reduced cost to parents.

c) This would provide better access to insurance for single and/or unemployed parents.

d) Both indemnity and Managed Care programs could be utilized.

7) Universal Health Plan

a) Level One
   1. First-come, first-served type of availability
   2. Oriented to the relief of pain and suffering
   3. Nursing Care
   4. Simple mental health care available

b) Level Two
   1. Nutrition
   2. Sanitation
   3. Health promotion
   4. Prenatal care
   5. Prevention Care (immunization)

c) Level Three
   1. Antibiotic treatment
   2. Protection against recurrent infection (immunization)

d) Level Four
   1. Emergency medicine
   2. Primary Care
   3. Simple Surgery and rehabilitation
   4. Inexpensive Diagnosis and therapy (limited lab and technologies)

e) Level Five
   1. Advanced form of medical care
   2. Restoration care
      a. advanced surgery
      b. cancer chemotherapy
      c. extensive rehabilitation
   3. Highy technological care
      a. Dialysis
      b. Open heart surgery
      c. Organ transplant

Obviously a universal plan will give access to the minimal necessities of Health Care but will ration health care as well. It will establish varying levels of care based on availability, economic and social usefulness, i.e., individuals will have the burden of proof that advanced treatment would be of social value.

8) Minimal Standard Access to Health Care for All Americans

a) Shall we consider establishing a "basic benefit package" that should be available to all Georgia citizens?

b) How do people in underserved areas of the State access the medical care delivery system?

c) Is there a system already available for basic health care that would require only increased financial support?

9) Basic Health Care Financed by Limited Liability and Federal and State Tax Credits

a) Physicians supplying discounted or free basic health care will have increased liability and expenses. I feel that an intangible trade-off is necessary. The patients under this plan *would have limited access to liability compensation,* i.e., access to the legal system could not and probably would not be limited, but the incentives for compensation liability could be reduced by putting stringent caps on proposed malpractice and pain and suffering compensation. This needs to be part of any plan approved by MAG.

b) To offset expenses, Federal and State tax credits could be given based on an acceptable formula.

Obviously there are no simple solutions, nor one single answer. Therefore, I would like to make the following recommendation.

Recommendation

"That the Ad Hoc Committee for Senior Citizens Advocacy continue to develop a plan which the Medical Association of Georgia could support and present to the Governor of our State, representing a system that would improve access to health care and maintain the independence of the private sector of medicine."

HOUSE ACTION

Adopted as amended by addition of the following phrase: "and that this activity be coordinated with other appropriate committees."

Also serving on Reference Committee A were (L to R): Phillip K. Rhyne, a medical student; John Ed Fowler, M.D.; William A. Wolff, M.D., and E. Dan DeLoach, M.D.

SENIOR CITIZENS ADVOCACY COMMITTEE

Bob G. Lanier, M.D., Chairman

In its deliberations this year, the Committee has considered items referred from the 1989 House of Delegates.

The following 1989 recommendations of the Senior Citizens Advocacy Committee have been successfully implemented:

—MAG continues to urge physicians to continue to see Medicare patients and help them deal with current or ongoing problems with Medicare.

—MAG has devoted much of its energies this year toward educating physicians and senior citizens about changes in the Medicare program and the potential impact of these changes on the physician and the beneficiary.

—A Medicare Fact Sheet and patient information brochure have been developed and are being distributed by the MAG Public Relations Department.

—Physicians and patients are encouraged to call MAG about Medicare problems. This is proving to be an excellent service.

Nursing Homes and Personal Care Homes (Res. 42)

This resolution requested the Senior Citizens Advocacy Committee to: 1) study the current status of nursing homes and personal care homes in Georgia, 2) advocate for universal optimal care in these facilities, and 3) advocate for appropriate legislation to ensure the implementation of these recommendations. The Committee did not feel that legislative activity this year was appropriate because of the various federal and state changes underway at this time, but did work with changes in the regulatory arena.

OBRA 1987 (Federal Budget Reconciliation Act) included extensive changes in conditions for participation and requirements for long term care facilities directed toward

improving the quality of care provided in these facilities. These provisions have an implementation date of October 1, 1990. As might be expected, federal rules and regulations to implement these provisions were not finalized until late 1989. The law mandates implementation whether federal regulations are published or not. Therefore, the Department of Medical Assistance (Medicaid) began developing its own regulations including sanctions for noncompliance. The Department of Medical Assistance accepted MAG's recommended changes to these proposed regulations, which will now be modified to comply with the federal regulations.

The most controversial issue centered around the required training of nurses' aides. Effective January 1, 1990, no individual may work in these facilities as a nurse's aide for more than four months unless that individual has completed a training and evaluation program or a competency evaluation approved by the State certifying that individual as competent to provide nursing and nursing related services.

There are other specific requirements in these regulations relating to quality of life and quality of care which may impact on the quality of care provided in those facilities.

The Committee concluded that a study conducted in this changing regulatory environment would be premature. The issues of long term care quality and cost are sure to receive increased attention from legislative and regulatory agencies. The Georgia State Health Planning Agency is currently (through April '90) conducting public hearings throughout the state relating to long term care problems and possible solutions.

This Committee will continue to monitor federal and state activities. At some future date, it may be appropriate to conduct a survey to determine if the quality of care is improving as a result of these actions.

Voluntary Medical Care Program

Your Committee has directed its energies this year primarily toward the development and implementation of a voluntary medical care program for senior citizens living at or below 150% of the poverty level.

The MAG Board of Directors referred the following related House actions to this Committee:

—recommendations of the Committee that a voluntary medical care program be developed;
—a recommendation that a Committee be appointed to evaluate and consider a plan comparable to that of the Kentucky Medical Association to increase access to health care in Georgia; and
—a resolution to the effect that, although most members already comply, all members of MAG participate in voluntary acceptance of Medicare assignment for all patients who are deemed medically indigent and who may otherwise be deemed eligible by the physician.

The Committee reviewed:

—material relating to voluntary medical care programs in Kentucky, Minnesota, Ohio, South Carolina, and MAG Operation Care; Texas hot-line for senior citizens; and voluntary medicare assignment programs in a number of states and counties;
—data and brochures relating to Medicare provisions and problems;
—services available through the State, AARP, and other senior citizens organizations;
—AMA informational material;
—brochures and other educational material relating to improving quality of life for older people; and
—a February 28, 1989 report of the U.S. Senate Special Committee on Aging.

It met numerous times via telephone conference calls to discuss various options as to what might be best for Georgia, given the current state of unrest about Medicare and indigent care in general.

As a result of these considerations the Committee presented a proposed voluntary Medicare care program to the September, 1989 MAG Board of Directors. The Board approved the following components:

NAME: PHYSICIANS CARE — (statement of philosophy and extent of services provided)

PURPOSE —
—to assure access to physician services by the elderly poor (both Medicare eligible beneficiaries *and* the uninsured)
—to document that physicians are already providing care to the most vulnerable elderly and are willing to do more
—to establish a forum to provide physician-oriented information to your patients, their families, our legislators and others

ELIGIBLE BENEFICIARIES — Category 1: People 65 or over, eligible for Medicare with an annual income ceiling of $8,950 (1 person) or $13,425 (couple). Category 2: People 65 or over, who have no medical insurance, with an annual income ceiling of $8,950 (1 person) or $13,425 (couple).

SERVICES TO BE PROVIDED — Participating physicians will agree to see eligible recipients at least one time to evaluate an acute condition and, with the patient, determine the extent of ongoing care to be provided by the physician.

Computerized Physician Participation status will be maintained by MAG.

Patient eligibility will initially be determined by MAG. Assistance of other groups will be considered at a later date.

All physician and patient information will be held personal and confidential.

Although we anticipated some reluctance to participate due to the intense dissatisfaction with the administration of the Medicare program in Georgia in 1989, and the belief that most physicians are rapidly reaching their reasonable limit in provision of indigent and reduced-pay care, physician response has been far less than we had hoped.

After an all-member mailing, publication of the participation form in two MAG Newsletters, providing information via correspondence, telephone calls, and personal presentations to hospital medical staffs and various specialty societies, and personal telephone calls by members of the MAG Auxiliary to physicians in the metro Atlanta area, we have received the following response. It should be noted that the Board of Directors of the Academy of Family Physicians recently voted to support the program. The Academy mailed letters of support and participation to its 700+ membership in March '90. At the time of this report, responses have begun to arrive.

Status Report March 28, 1990

Total MAG Membership	7,224
Forms received	1,127
Positive	914
Negative	191
Faulty response	22

Many who did not respond or responded negatively, indicated that they were already providing this care and therefore did not feel they needed to participate in PHYSICIANS CARE.

It is felt that this number of positive responses is insufficient to launch the program statewide, therefore, no effort has been directed as of yet toward signing up beneficiaries.

The Committee feels that a program of this nature would provide strong evidence that mandatory assignment is not needed, and prove once and for all to the General Assembly that assignment tied to liscensure is a bad idea.

What to do about indigent care is an issue that is of increasing importance in both clinical and political arenas. There is no doubt that it will be addressed in some manner legislatively at both federal and state levels. It's more expedient to deal with the issue through the Medicare/Medicaid budgetary process. Your Committee feels an urgency to establish a mechanism to meet the needs of the elderly poor before the legislators decide for us.

National Practitioner Data Bank

Although this subject was not included in Committee discussion, your Chairman shares your concerns about the implementation of the 1986/87 federal legislation which requires the establishment of this Data Bank. The attached information has recently been brought to our attention. We felt it should be made available to the physicians of Georgia.

(Editor's Note: For a more detailed report of the Data Bank, contact the Director of Community Services at MAG Headquarters.)

Recommendations

1. That the Senior Citizens Advocacy Committee continue to function and work toward the further development and implementation of PHYSICIANS CARE.

2. That MAG, through this Committee, monitor the activities of and evaluate the final report by the Governors Access to Health Care Commission.

3. That MAG evaluate the potential of developing a comprehensive plan for the delivery of health care in Georgia.

HOUSE ACTION

Adopted Recommendations 1 and 2. Did not adopt Recommendation 3 and adopted the following Substitute Recommendation: "That MAG promptly investigate the repercussions of current regulations governing nursing home care in order to inform the state and Federal legislatures of the impact on health care in nursing homes in this state."

Attachment 1

National Practitioner Data Bank

Background

1. Title IV of Pub. L. 99-660, the *Health Care Quality Improvement Act of 1986*, as amended by Pub. L. 100-177, mandated the establishment of the National Practitioner Data Bank. Section 5 of Pub. L. 100-93, the *Medicare and Medicaid Patient and Program Protection Act of 1987*, expanded the scope of the Data Bank's operation.

2. The Title IV Regulations were published in the *Federal Register* on October 17, 1989 (54 FR 42722-47234).

3. A 5-year $15.9 million contract to establish and operate the Data Bank was awarded effective January 1, 1989, to Unisys. The Data Bank will open under the Title IV requirements only. Implementation of Section 5 provisions will follow at a later date, after public review and comment on Section 5 rules. No information will be reported to the Data Bank until the date of its opening and no retroactive reporting will be required. The opening date will be established and published in the *Federal Register*.

Title IV Provisions

Who Must Report And What Must be Reported to the Data Bank

1. *Malpractice payments:* Any entity (insurance company, self-insured hospital, etc.) or individual (self-insured physician or dentist, etc.) that makes a payment on behalf of any licensed health practitioner as the result of a claim or judgment for medical malpractice *must* report requisite data to the Data Bank and to the appropriate State licensing board(s).

2. *Licensure actions:* State Medical and Dental Boards *must* report to the Data Bank disciplinary actions taken against the license of a physician or dentist.

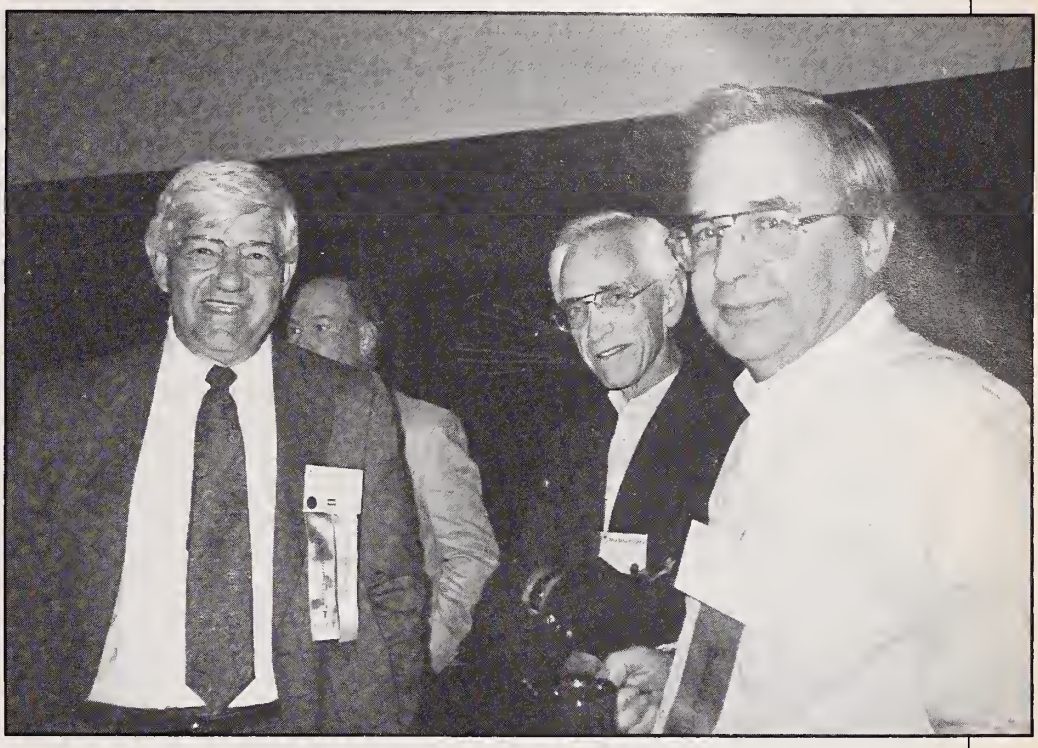
3. *Professional review actions:*

Clinical privilege actions: Hospitals and other health care entities, such as HMOs and certain medical and dental group practices *must* report certain adverse actions taken against a physician's or dentist's clinical privileges. These are actions based on the practitioner's professional competence or conduct which will last more than 30 days.

Society membership actions: Professional societies *must* report an adverse action taken against the membership of a physician or dentist when they reached that action through a formal peer review process and when the action was based on the practitioner's professional competence or professional conduct.

Who May Report And What May be Reported to the Data Bank

1. Hospitals and other health care entities *may,* if they choose to do so, similarly report adverse actions taken against the clinical privileges of licensed health care practitioners other than physicians and dentists. Professional societies of health disciplines other than medicine and dentistry *may,* if they so choose, similarly report adverse actions taken against the membership of these health care practitioners when they reached that action through a formal peer review process and when the action was based on the practitioner's professional competence or conduct.



Meeting between committee meetings are (L to R): William C. Collins, M.D., of Atlanta; Carson "Bucky" Burgstiner, M.D., of Savannah; George D. Miller, M.D., of Atlanta; and Martin J. Moran, M.D., of Atlanta.

Who Must Query the Data Bank

1. All hospitals *must* query the Data Bank every 2 years regarding physicians, dentists and other health care practitioners on their medical staffs or those to whom they have granted clinical privileges. Hospitals also *must* query the Data Bank when they are considering an applicant for a medical staff appointment or for clinical privileges. Hospitals may query at other times, as they deem necessary.

Who May Query the Data Bank

1. State licensing boards *may* query the Data Bank regarding a physician, dentist or other health care practitioner.

2. Health care entities in addition to hospitals *may* query the Data Bank when they are entering employment or affiliation arrangements with physicians, dentists or other health care practitioners.

3. An attorney who has filed a medical malpractice action or claim against a hospital *may* query the Data Bank for information regarding a specific physician, dentist or other health care practitioner who is also named in the action. *However,* this information will only be disclosed if the attorney submits evidence that the hospital failed to request information from the Data Bank, as required by law, and the information may be used solely with respect to the medical malpractice action against the hospital.

4. Individual physicians, dentists and other health care practitioners *may* query the Data Bank concerning themselves.

Section 5 Provisions

1. Any authority of a State responsible for the licensing of health care practitioners or health care entities must submit requisite data to the Data Bank regarding licensure disciplinary actions taken against practitioners or entities.

General

1. Individuals on whom a report has been made to the Data Bank will routinely receive a copy of that report.
2. An individual may obtain his or her record at no cost, while others who are authorized to obtain Title IV information from the Data Bank will be charged a fee.
3. Aggregate data which do not permit the identification of any particular health care entity, patient, physician, dentist, or other health care practitioner will be available to interested persons. These data will be available about a year after the Data Bank opens.
4. The Data Bank will conduct an educational program to inform interested individuals and entities concerning the requirements of Title IV, its regulations, and procedures for filing and requesting information from the Data Bank.

HOSPITAL MEDICAL STAFF SECTION

William B. Jones, M.D., Chairman

Last year brought forth a reawakening and revitalization of a newly organized MAG-Hospital Medical Staff Section. During 1988 and 1990 a formally appointed Committee or Governing Council was organized with at least one member representative from each of the ten MAG districts and eight at large members.

Three major meetings were held during the year — the first meeting held in August, 1989 in Callaway Gardens in conjunction with the Georgia Hospital Association's seminar on, "Delivering Quality Care: The Hospital's Balancing Act"; the second one held on February 3, 1990 preceding the MAG Leadership Conference; and the third scheduled to immediately precede the 1990 MAG House of Delegates. Several subcommittee meetings were also held during the interim. Medical Staff Model Bylaws, the PRO third scope of work, the National Practitioner Data Bank, Medical Staff self-governance, a HMSS South-Eastern Caucus, and consultation and support to individual medical staffs — these and other topics had our attention. Where have we made our greatest investments? Here are some of the highlights:

Development of Association Model Medical Staff Bylaws

With the legal assistance of Richard H. Vincent, Esq. and Susan Cowan Atkinson, Esq. of the law firm of Vincent, Chorey, Taylor, and Feil, a Medical Staff Bylaws Subcommittee embarked upon the preparation of a set of model bylaws as a resource for Georgia medical staffs as they review and revise their bylaws in compliance with new federal laws and Joint Commission standards. At least ten or more state medical societies have published model bylaws within the last two years, including guidelines for quality assurance programs and other medical staff functions.

The Model Bylaws are written from the perspective and interest of the medical staff. It is the Committee's view that until recently, physicians have tended to under-utilize the medical staff as a vehicle for accomplishing collective professional goals within the hospital setting. In some cases, it is felt, that physicians have abdicated considerable responsibility (and therefore authority) to the hospital administrator, the hospital attorney or others whose objective may conflict or be inconsistent with the interest of the physicians. The model bylaws attempt to strengthen the position of the medical staff. With some adaptation, they are applicable to hospital medical staffs of varying size and complexity. It is hoped that final review and publication of the bylaws can be made by June 1, 1990. We have already had a request from a hospital in the state for these bylaws.

Progress of the National Practitioner Data Bank

The final regulations of the National Practitioner Data Bank were published in the *Federal Register* on October 17, 1989. An overview and analysis of the regulations were provided to the MAG-HMSS Executive Committee for information concerning mandatory reporting of professional review actions taken by the hospital medical staff. Dr. Ralph Murphy from the Georgia Medical Care Foundation has spoken to the Committee about the expected implementation dates now slated for sometime in July/August 1990, and the expected process for reporting. The Committee continues to monitor this activity and will be prepared to alert physicians about the functioning of the Data Bank and any risks of broad dissemination of information which is reported.

Formation of an AMA-HMSS Southeastern Caucus

Through discussion with other southeastern HMSS delegations, a decision has been made to meet and organize as a southern caucus

at future AMA-HMSS meetings. This move, we feel, will further strengthen Georgia's voice on a national level with hospital medical staff concerns and push forth the momentum of interest and involvement.

Addressing Individual Medical Staff Concerns

At the end of December, a significant event occurred in our state related to the rights of hospital medical staffs. Alledged, a private hospital unilaterally abrogated the staff privileges of all physicians, and made reappointment contingent on signing a "loyality oath" to the hospital. Testimony was given by myself, as chairman, to the JCAHO when the latter made its on site visit to the hospital. The resolution of these events is awaited, but the HMSS feels that we should use all of our efforts to support the physician rights in the hospital.

Recommendations

1. That MAG support the creation of a southeastern HMSS caucus as mentioned above.
2. That the MAG, through the HMSS, develop a model Quality Assurance Plan after the model bylaws are completed.
3. That the MAG encourage physicians to use the HMSS as a resource in addressing staff issues.
4. That the MAG, through the HMSS, keep the organization appraised of HMSS developments at a national level, and the effect these might have on Georgia.
5. That the MAG support publication and promotion of the MAG-HMSS Model Medical Staff Bylaws.

HOUSE ACTION

Adopted Recommendations 1, 2, 3, and 4. Adopted Recommendation 5 as amended: "That MAG support the concept of HMSS development of model medical staff bylaws with referral to the MAG Board of Directors for action after the HMSS has a completed document."

EMERGENCY MEDICAL SERVICES COMMITTEE

Roger Chapman, M.D., Chairman

Charge:

Established to encourage and coordinate Georgia physicians and state federal agencies to work together in the development of a logical, systematized and medically sound emergency health services delivery system in Georgia.

The Georgia Department of Human Resources is charged by Executive Order and pursuant planning to coordinate the medical care to be provided in emergencies and disasters occurring in our state. The Emergency Medical Services Section does coordinate ambulance service statewide and District Health officers to have contact with medical resources in their individual districts. However, very little attention has been directed toward the development of a statewide coordination plan for the delivery of medical care in the event of large scale emergencies and disasters when the capacity of the local ambulance service-trauma center systems are exceeded.

At the request of Thomas W. Moody, Emergency Management Director, Office of Community and Inter-Governmental Affairs and the expression of interest from others, the MAG Emergency Medical Services Committee invited representatives of the DHR including the Emergency Medical Services Section; the Georgia Chapter, American College of Emergency Physicians; the Trauma Committee of the Georgia Chapter, American College of Surgeons and other interested parties to discuss disaster planning and other issues relating to emergency medical care.

Although all interested parties were not able to attend the discussion gave rise to very grave concerns. The bottom line: there is no real functional statewide coordination plan for delivery of medical care in a disaster.

Most metropolitan areas do have existing written plans for the delivery of disaster care. The efficiency of these systems vary. Test drills appear to indicate a real need for trained triage teams and education, training and rehearsal drills of all persons who would be expected to be at the scene of any major disaster. One should also bear in mind that the definition of a major disaster may depend on where you are. What response occurs in non-metropolitan areas appears to be subject to whatever individuals and/or agencies may be free to respond. There is a need for every governmental body to have a functional disaster plan.

The state relies extensively on the private medical community for the first level of emergency and definitive medical care needed in all disaster situations. There is a statewide plan but it has yet to be tested to assure that this response is forthcoming and coordinated with appropriate triage protocol.

There is reluctance to share protocols from one agency to another. There may be confusion as to what responsibilities and function of each person at the scene may be. There are apparently no statewide protocols.

Transportation is a major problem in some areas of the state. For example, there are limited helicopter transport services available in South Georgia, only Fort Benning provides this service to a major area of the state.

There is an increasing need to educate all responders who to deal with toxic exposure and hazardous waste spills.

(L) Larry Brightwell, M.D., President of Muscogee County Medical Society, host county for this year's Annual Meeting; and Edward J. Waits, M.D., from the Medical Association of Atlanta, and Chairman of MAG's Impaired Physicians Program.

Your Committee feels there are resources available to address these concerns.

Recommendations

1. That the MAG use this Committee as a forum where all interested parties and agencies can convene to discuss and resolve these issues and work towards the development of a statewide plan that will assure that victims of any medical disaster in our state will receive prompt and appropriate attention.
2. That MAG encourage physicians of Georgia to participate in disaster medical planning and practice.

HOUSE ACTION

Adopted Recommendation 1 as amended: "That the MAG use this committee as a forum where all interested parties and agencies may convene to discuss and resolve issues relating to emergency medical services and work toward the development of a statewide plan for the delivery of medical disaster care."

Adopted Recommendation 2.

IMPAIRED PHYSICIANS COMMITTEE

Edward J. Waits, M.D., Chairman

The Medical Director for the Impaired Physician Program, Dr. John D. Lenton, assumed his duties on October 1, 1989, as a part-time (20 hours weekly) contractor.

During the succeeding six-month period (Oct. '89 through Mar. '90), the Medical Director visited each of the 15 treatment centers statewide which have been approved by the Composite State Board of Medical Examiners for treatment of physicians with psychoactive substance use disorders and/or psychiatric illness. The representatives of those programs uniformly offered their cooperation and support, but, for the most part, were not clear about their relationships with the MAG program and the Composite State Board of Medical Examiners. Clarification and formalization of these relationships is certainly desirable, and calls for further promotional and educational effort. One goal to press for is a uniform program of aftercare and monitoring which should be clinically sound as well

as acceptable to the Composite State Board.

Recovered physicians throughout the state are being personally contacted by the Medical Director to organize regional support groups (e.g., Caduceus Clubs, local chapters of International Doctors in Alcoholics Anonymous), where such do not already exist, and from these groups volunteers are being recruited to assist with intervention and with monitoring procedures for recovering physicians. It will be essential to maintain close contact with these groups, and quarterly visits to them are planned. Thus far, enthusiastic responses have been obtained in Athens, Atlanta, Gainesville, Macon, Savannah and Statesboro.

Hospitals around the state are initiating in-house programs for the identification of impaired staff members, leading to intervention and rehabilitation while safeguarding the public interest. Such efforts are variously known as wellness committees, well-being programs, physician assistance programs, etc. In all instances, the primary motivation is protecting the patient from potential harm.

Several hospitals have contacted the Impaired Physician Program for help in establishing their programs, and the Medical Director has provided information, has met with hospital committees, and has offered to assist with interventions, referrals to evaluation and treatment, and with aftercare. This advice has been well-received, and it is anticipated that these hospital programs will increase the rate of detection of impaired physicians over the near future, similarly increasing the need for MAG assistance. Continued and increasing liaison with hospital administrative and medical staffs is essential to the success of our MAG program.

At their invitation, the Medical Director met with the Board of Directors of the Georgia Psychiatric Physicians Association to discuss a number of long-standing complaints which had been directed to them concerning the MAG Impaired Physician Program. While many of the complaints were about State Board-approved treatment programs, and should, perhaps, have been directed to the Board, it was also apparent that our MAG program is poorly understood by the GPPA in terms of authority, function and goals. If the principal association of psychiatrists in the state is not adequately informed about the program, one could surmise that non-psychiatrists throughout Georgia are similarly poorly-informed about physician impairment and the considerable help available through MAG. Indeed, I have found this to be generally true during my visits to hospitals and physician groups. An intensive marketing effort is indicated, to include: announcements in MAG publications; addressing component societies, auxiliary groups, and hospital personnel; and mailing descriptive brochures to physicians.

An effort has been initiated to effect a memorandum of understanding between the MAG Impaired Physicians Committee and the Composite State Board's Committee so MAG can be of greater help to the State Board. There is much work yet to be done in this regard, and some major areas of concern expressed by the State Board are the effectiveness of monitoring and reporting of relapses by treatment providers. As an initial step, the State Board requested that the Committee supply them with criteria for selecting treatment programs appropriate for impaired physicians, and this has been done. Were MAG able to establish a uniform process of monitoring recovering physicians, in cooperation with treatment providers, and to centralize monitoring data (e.g., participants compliance with aftercare agreements/plans, results of urine drug screens), the MAG program could help to relieve the State Board's burden and at the same time be very helpful to treatment programs and participants. (NOTE: Confidentiality would be maintained in accordance with Federal statutes; however, statistical data about participants could be shared with the State Board.)

Some of these needs are already being addressed, to a degree, and a summary of activity for October 1, 1989, through March 31, 1990, is attached. Greater effort is needed, however, to realize these goals, and it is anticipated that most of the Medical Director's time will be consumed by personal contacts with recovered/recovering physician groups, treatment providers, hospital committees, component societies and auxiliaries, and establishing liaison with the Composite State Board. This will necessitate considerable travel during the coming year. Additionally, there is an increasing need for secretarial services (e.g., handling correspondence, reports, data, telephone contacts and scheduling, typing and filing) pertinent to the successful operation of the Program. It is also important that the Medical Director attend relevant state and national meetings to remain abreast of developments and to network with representatives from other programs. The Impaired Physicians Committee is moving toward seeking sources of funding outside of MAG, and a basic plan is being developed. A subcommittee will be appointed to oversee funding activities.

Summary of Activity
1 Oct 89 - 31 Mar 90

Contacts (Total) RE:	
Physician Impairment	39
Interventions 3	
Entered Treatment	2
Refused Evaluation/Treatment	1
Enrolled in Program/Continuing Care	13
Self-Referred	11
Referred by State Board (CSBME)	2
Pending, Insufficient Data, Etc.	4
Visits to Approved Treatment Programs	15
Consultations with Hospitals Requesting-Assisting with Staff Well-Being Programs	4
Requests for Information Only	3
Presentations, Physician Groups, Medical Students	4

Pertinent Meetings/Consultations:
National Association Impaired Physician Program Directors (Atlanta)
David Dodd, M.D., Tennessee Impaired Physicians Program (Memphis)
Roger Goetz, M.D., Impaired Practitioner Program of Florida (Fernandina)
Florida Society of Addiction Medicine (Orlando)

Recommendations

1. Develop a uniform program of aftercare and monitoring which is clinically sound and is acceptable to treatment providers and to the Composite State Board of Medical Examiners.

2. Increase awareness of the services available from MAG, and increase penetration, by intensifying marketing efforts, and by increasing interaction with component societies, auxiliaries, and hospital staffs.

HOUSE ACTION

Adopted Recommendation 1 as amended: "Develop a uniform program model for aftercare and monitoring which is clinically sound and is acceptable to treatment providers and to the Composite State Board of Medical Examiners."

Adopted Recommendation 2 and added the following Recommendation: "That the Impaired Physician Committee or its Medical Director may not negotiate a contractural relationship with the Composite State Board of Medical Examiners without the MAG Board of Directors approval; and that in matters concerning physician confidentiality at the intervention stage, the Board of Directors may not enter into further agreements with the Composite State Board of Medical Examiners without the express permission of the House of Delegates."

MEDICAL SCHOOLS COMMITTEE

Albert A. Carr, M.D., Chairman

Following a mandate from the House of Delegates that we hold a conference each year to allow MAG leaders to discuss issues of common concern with the deans of Georgia's four medical schools, we held MAG's Fourteenth Conference on Medical Education last October 20-21 at the Georgia Center for Continuing Education on the University of Georgia campus in Athens.

Our conference is predicated on informal discussion, so we keep our group small by extending personal invitations. This year, among our 23 attendees, we had with us the top medical leadership of both town and gown in Georgia: President Tedesco and Dean Eastwood of the Medical College of Georgia, Dean Houpt of Emory, Dean Skelton of Mercer and Dean Alfred from Morehouse. Representing the Medical Association of Georgia were our President, Immediate Past President and President-Elect plus myself and several other members of our Medical Schools Committee.

On our agenda we discussed medical manpower in our state, and ways of enhancing practicing physician's access to individualized programs of continuing medical education. Our main topic, however — on which we spent much of Friday afternoon and all of Saturday morning — was the current competition for "paying patients" between private practitioners and medical school faculty physicians, and our collective responsibilities for providing medical care to the indigent ill.

We quickly established some realities:

— it costs 33% more to treat a patient in a teaching hospital than in a community hospital;

— medical care costs are higher in the older population compared to the younger; they are especially high during the terminal portion of a patient's disease;

— medical technologic advances and increased use are primary forces in driving up the cost of medical care, but in a crisis, most people want that technology used;

— 18% of Georgians are too poor to afford medical care (this includes *workers*, as well as unemployed); and

— 80%-90% of the indigent care in Georgia is provided in teaching hospitals, mainly Grady Hospital and the Medical College of Georgia Hospital and Clinics.

We discussed our profession's responsibilities for providing medical care to these sick poor. We came to an understanding that while physicians are usually blamed most for the high cost of care, the entire system — patient demands for the most sophisticated treatments, hospitals' attempts to remain solvent and operate at profits, and insurers and employers — is to blame. We resolved that it is a mistake for the medical profession to assume single-handed responsibility for the high cost of care. We concluded also that the present efforts by the above parties (providers and payors) to address the problems of cost are simply not working, and that physicians are being made a scapegoat for the failures of the system as a whole. The problem is, what is the most cost-effective use of our technology? This technology is important for generation of monies to support hospitals, especially teaching hospitals. At the same time, many of us felt teaching program costs should be funded by the State, County, and Federal governments, rather than from "profit" resulting from patient care, rendered by teaching physicians to those with an ability to pay.

We discussed the possibility of the medical profession leading public dialogue on the basic issues of the problem. For instance, shall we use public tax dollars for a coronary bypass for an an 80-year-old woman with a life expectancy of 36 months after the procedure? We agreed that a positive, affirming campaign (not self-serving) could be useful in shaping rational alternatives for our public leaders. Physicians are concerned about cost in dollars related to therapeutic effectiveness that can not be measured in dollars. On the other hand, public policy-makers and insurance companies are concerned about cost in dollars related to benefits in dollars. The tension between the providers' goals and the payors' goals could lead to a rationing of medical care!

We talked about the need for increased funding for medical education and postgraduate medical education, now that research grants to medical school faculty are dwindling, and Medicare cutbacks are affecting residency programs and teaching hospitals. We also discussed, as we have for the past two years, how medical school faculty are being increasingly diverted from teaching and research toward private patient care in order to generate income for the institution. There is a need for more "State" and "County" support of teaching programs. A good formula would be for an additional 33% of present hospital expenditures to be added for the teaching process. This would not include salaries of teaching physicians.

A key point in our agenda was the participation of State Representative Lauren "Bubba" McDonald, Chairman of the House Appropriations Committee. We agreed on a statement of the problem: that costs of medical care for our indigents will increase in the future; funding resources for that care will be increasingly hard to come by; and that private doctors, the medical schools, state government and the public health sector must cooperate toward a solution. Funding for teaching programs by the State of Georgia was never intended as a method for the providing of medical care for our indigent population. That is an issue separate from teaching, but politically it is related. Representative McDonald urged us to come up with some "bite-sized" goals for consideration by the General Assembly. He pledged his support.

Accordingly, we worked at developing a task-list of "bite-sized doables":

1. *Increase state capitation funding for medical education and postgraduate medical education at all medical schools including the Medical College of Georgia.* Presently Emory, Mercer and Morehouse receive from the state $9,350 per medical student. To assure continued excellence in our teaching of future physicians in Georgia, we believe the legislature should be vigorously petitioned to increase its medical education capitation levels, with corresponding increases in funding for MCG. This funding must take into account the present and the future needs for providing trained physicians to care for Georgians.

State funding for residency programs comes through 1) the family physician capitation program (institutions training about 127 FP residents receive $21,500 per resident) and 2) a general residency capitation fund, which represents around $2½ million divided among training institutions on the basis of residency numbers. Last year Grady got more than half ($1.3 million, of nearly $2.4 million).

2. *Study why physicians voluntarily treat the indigent for free.* How do we stimulate physicians to volunteer free services to the poor, when established practitioners are already giving up so much free care, and young doctors are saddled with debt? We discussed several responses. First, because physicians are only one factor in the medical care delivery system, we need to resolve that while we are a caregiving profession, if physicians provide care at no compensation, then so should others.

We agreed that we need to conduct some *in-depth study of the psychology of volunteerism* — what are the forms of public service, and its rewards to the donor? The call for volunteerism, once appropriately identified, could then be made not only to medical professionals, but pharmaceutical firms, etc. The

medical schools, for instance, could *survey physicians and other providers as to why they donate*, say, an afternoon a week in caring for the indigent at teaching hospitals.

We think that a well organized "survey of professional volunteerism" would apply not only to physicians, but also to other professionals who serve the public good. We also think the findings of such a survey could prove useful to state government and its agencies relating to public service. Given these benefits, we believe that MAG should seek state funding of such a survey.

3. *Explore linking the provision of free medical care for indigents with some form of educational subsidy, tax credit, or some other method* to help physicians provide "free care." This is especially true for primary care physicians.

Senator Nunn has introduced legislation calling for a program of national youth volunteerism — several years' public service in return for federal education subsidies. Could we not do the same thing in Georgia? For instance, just as the State Medical Education Board rewards physicians for serving in rural or other "underserved" areas, could not the *state develop some similar inducement for medical service to the indigent, either through educational subsidies* to young physicians, *or tax breaks* for established practitioners? We think this proposal is very much worth our further examination.

Still another inducement, in the wake of recent passage by the General Assembly of mandatory CME, would be to equate indigent medical care with continuing education — *e.g.*, X hours of CME credit earned in return for Y amount of free patient care to the poor. This concept has merit, too.

We believe that the above ideas are worthy of MAG action in the coming year, and accordingly submit them as resolutions to the House.

I furthermore wish to express my sincere appreciation to our hard-working Committee members: Joseph P. Bailey, Jr., M.D.; Harry N. Dorsey, M.D.; Lois T. Ellison, M.D.; James S. Maughon, M.D.; William M. McClatchey, M.D.; George W. Shannon, M.D.; James K. Van Buren, M.D.; William C. Waters, III, M.D.

Recommendations

1. That the Medical Association of Georgia collaborate with the Joint Board of Family Practice or other organizations to research the issue of capitation funding for medical education and postgraduate medical education, and to introduce to the State Office of Planning and Budget requests for the increase of that funding for all four of Georgia's medical schools.

2. That the Medical Association of Georgia, through its Medical Schools Committee, Public Relations Committee, and other appropriate committees: 1) conduct a survey of existing programs in Georgia wherein physicians deliver free medical care to the indigent, and 2) explore the means of reinforcing successful programs as well as developing new incentives for physician volunteerism.

3. That the Medical Association of Georgia, through its Council on Legislation, Medical Schools Committee, as well as other appropriate Committees, study means of cooperating with the State government to develop financial inducements for physicians' medical service to the indigent.

HOUSE ACTION

Adopted Recommendation 1 as amended: "That the Medical Association of Georgia collaborate with the Joint Board of Family Practice or other organizations to research the issue of capitation funding for medical education and postgraduate medical education, and to introduce to the State Office of Planning and Budget requests for the increase of that capitation funding and the equity of the distribution of this funding for all four of Georgia's Medical Schools."

Adopted Recommendations 2 and 3.

OCCUPATIONAL HEALTH COMMITTEE

C. Lyn Crooms, M.D., Chairman

Your Occupational Health Committee has met three times this year.

In September 1989, the Committee reviewed its charge and discussed issues related to occupational medicine that potentially impact on the general practice of medicine in Georgia:

— Worker's Compensation issues — many changes have been and are being made which Georgia physicians need to know about, e.g. fee schedule and occupational injury compensation.
— Federal and state legislation and regulation changes — primarily the need to stay up to date in a changing regulatory environment.
— May 30, 1989 Proposed OSHA Regulations relating to occupational exposure to bloodborne pathogens, specifically Hepatitis B Virus (HBV), Human Immuno-deficiency Virus (HIV) and other bloodborne pathogens. It was the consensus of the Committee that these proposed regulations reflect current OSHA standards.

— Exposure to hazardous waste. The Committee felt physicians in general should be made aware of what to do when they see patients who may have been exposed to hazardous waste materials.
— Other areas of concern were:
*confidentiality of medical records
*drug testing
*ethical recommendations relating to what an employee, or potential employee, can or cannot do (pre & post procedures for employment physicals)
*extent of medical information material in employee file
*need for occupational medicine residency training programs

The Committee reviewed eight pieces of legislation before the 1990 General Assembly relating to Worker's Compensation. Concern was expressed about House Bill 1168 which provides that compensation shall not be allowed for an injury or death occurring when the victim is under the influence of marijuana or a controlled substance. The Committee felt that "under the influence of a controlled substance" should be more clearly defined. This concern was expressed to MAG's legislative team. A summary of the changes made in the Worker's Compensation Act will be forthcoming at a later date.

The Committee expressed its desire to be informed and involved in the development of all relative legislation and/or regulations as early in the process as possible.

Workers Compensation (WC) Fee Schedule Update

It was understood that in 1988, the WC Board, with input from insurance companies, had prepared a fee schedule intending to distribute it to the medical community. The Metropolitan Atlanta Medical Care Foundation was asked to intervene. As a result, a panel of physicians was convened to provide physician input into the process. The outcome was the fee schedule subsequently published by the WC Board March 1, 1989.

The Committee was further advised that MAG had declined to participate in the development of a fee schedule early in 1987 — this was apparently due to concern about potential anti-trust issues and a general opposition to fee schedules. The current leadership is more receptive to becoming involved, with the understanding that anti-trust issues are not likely to occur in negotiations with a State regulatory agency.

It was reported that the Governor-appointed Medical Advisory Committee to the WC Board had considered the 1990 update (the law requires an annual update). The decision was made to put the schedule "on hold" except for minor adjustments in fees for office visits. This "revision" was distributed March 1, 1990. It was agreed that a representative of the Medical Advisory Committee would be asked to discuss the methods of appointment to, and the functions of, the Medical Advisory Committee to the WC Board at the next meeting of the Occupational Health Committee.

After further discussion, those present concurred that the MAG Committee on Occupational Health should request MAG Board of Directors approval of a draft letter to Mr. James W. Oxendine, Chairman, Workers Compensation Board, requesting commitment to an annual update of the WC Fee Schedule with the input of the Medical Association of Georgia. The Chairman will be responsible for drafting this letter and requesting MAG Board of Directors approval.

Consideration of Future Activities

At each of its meetings, the Committee discussed at some length the directions this Committee should take if indeed it continues its existence. Members felt that it should continue if it could provide a specific service to Georgia physicians and their patients who may be afflicted with a disorder associated with their occupation.

Each member was asked to submit recommendations for the ongoing function(s) of this Committee to T.R. Robinson, M.D. for compilation and distribution to the Committee for further discussion. The three categories outlined as follows: Representational/Liaison activities; Educational (scientific, technical, and administrative options); and, Structure/Composition of the Committee. These categories encompass the broad aspects of occupational health and the positive potential of an effectively functioning Occupational Health Committee. The major difficulty is that of determining our priorities in addressing the issues. The educational aspects involved may be met by articles in MAG publications and by Committee members making themselves available to provide assistance as needed by the MAG membership and staff.

The Committee further discussed the distinction between, and the overlap of, occupational health (including all aspects of prevention and treatment of illness or injury in the work place) as it concerns all physicians at one time or another, and the specialty of occupational medicine, to which a growing number of physicians are chosing to devote their entire professional practice. These physicians are an excellent resource to provide technical and clinical advice to those who are less intensively involved in the economic and regulatory factors, and the expanding variety of

work related disorders, e.g. drug abuse, AIDS, environmental factors, and stress related disorders.

The Committee chose to recommend two changes in the Committee structure and charge. It is the intention that with these changes, the Committee will maintain primary involvement of those physicians who practice the specialty of occupational medicine and expand its scope to more actively involve representatives of other closely related specialties.

Recommendations

1. That the composition of the Committee include interested representatives of Family Practice, General Surgery, Internal Medicine, Neurosurgery, Occupational Medicine, Orthopedic Surgery, Physical Medicine and Rehabilitation, Plastic Surgery, and Psychiatry.

2. That the charge to the Committee be changed from, "This Committee is established to inform physicians in Georgia of the significant changes in the field, particularly in the areas of Workman's Compensation, rehabilitation, and occupational study," to "This Committee is established to inform physicians in Georgia of the activities and changes occurring in the field of occupational health, including Worker's Compensation."

HOUSE ACTION

Adopted Recommendations 1 and 2.

THIRD PARTY PAYORS COMMITTEE

C. Peter Lampros, M.D., Chairman

"Health Care for Georgia's Elderly: Fair Payment for Medicare Services" — this was the title of MAG's recent statement to the U.S. Congressional Subcommittee on Health and the Environment and the primary focus of MAG and our Committee during 1989 and 1990.

The initial problems physicians and patients experienced at the beginning of the year with Georgia's new Medicare Part B Carrier, AEtna Life Insurance Company and HealthCare COMPARE, unfortunately did not subside. In fact, physicians, over the past 15 months, have probably experienced one of the most difficult and devastating events to their practice operations and their relationship with their elderly patients since the onset of the Medicare program some 20 years ago. It has taken the combined efforts of MAG's Executive leadership and various Committees, county medical societies, state specialty societies, and others to mount an aggressive and united front toward attacking these difficulties.

The key player in these events has been your own Joseph P. Bailey, Jr., M.D., Past President of MAG, who has been unrelenting in his drive, his time, and tenacity in solving the Medicare dilemma. While there is yet much to do, a significant number of concrete accomplishments have been achieved throughout the year with the Medicare program. A chronology of many of MAG's efforts throughout 1989 and 1990 are appended to this report. In terms of concrete accomplishments, I have highlighted some of the most notable ones below.

MAG Accomplishments:

- Influenced changes in HealthCare COMPARE policies and documentation requirements on comprehensive hospital and office visits, concurrent care, nursing home visits, and consultations;
- Detected and influenced corrections in physician specialty identification codes;
- Implemented Medicare Hotline to handle physician problems and questions;
- Detected physician clinical laboratory payment errors and gained correction;
- Influenced HCFA's reassessment of physician "coverage by a colleague policy" and delay of enforcement deadline;
- Influenced carrier to revise Explanation of Benefits to better define payments;
- Focused national public and legislative attention on Medicare crisis in Georgia resulting in various investigations and hearings;
- Identified system errors in payments to radiation oncologists, anesthesiologists, and radiologists for correction;
- Identified system errors in Medicaid/Medicare crossover claims for correction;
- Identified system errors in patient date of death resulting in nonpayments for corrective action;
- Detected failure of AEtna to properly develop claims in medical necessity denials; and
- Identified errors in physician 1990 profile and MAAC data for delay in participation sign up date.

Further Federal Physician Payment Reform (OBRA-89)

In addition to the complexities of carrier operations, physicians have been faced this year with one of the most important federal budget bills — The Omnibus Budget Reconciliation Act of 1989 — in the history of Medicare legislation. In particular, there are key issues in the areas of physician payment reform, expenditure targets, balance billing, physician referral, and medical care quality research and improvement.

The ACT includes a five year phase-in of the Resource-Based Relative Value System; establishment of the Medicare Volume Performance Standard; a requirement that even non-participating physicians file all Medicare claims whether assigned or not; cuts in reimbursement for over 200 CPT codes deemed "overpriced"; a fee freeze until April 1, 1990; a continuation of Gramm-Rudman reductions which will offset some of the Medical Economic index update next year; restrictions of referrals to outside clinical labs in which M.D.'s have an investment interest; and much more. The Committee has provided regular monthly reports in the MAG *Newsletter* of these requirements and their significance to medical practice.

Bringing Utilization Review Under Tighter Control

During 1989, the Association and the Third Party Payors Committee put forth considerable effort toward addressing physician problems with Third Party Utilization Review (UR) programs.

In June, at MAG's urging, State Insurance Commissioner Warren Evans called together a committee of UR interests to discuss possible solutions to physician problems in this area. Dr. Joe Stubbs, Dr. Louis Felder, and staff represented MAG on this Committee. Following several months of debate and controversy, the Committee arrived at a voluntary program for UR company certification and review. Health Insurance Association of America (HIAA) and utilization review company representatives, however, continued their objections to even a voluntary approach.

Consequently, MAG and the Georgia Hospital Association reviewed various proposals for draft legislation for this year's Session of the General Assembly. Using references from the AMA, the Kansas Medical Society, National Association of Private Psychiatric Hospitals and others, the MAG was instrumental in drawing up legislation which was introduced in the form of HB 1813. The bill was successfully passed and will require certification of and establish standards for the operation of UR companies in Georgia. Highlights of the new law include:

- Certification of all private review programs;
- Medical protocols developed by physician and specialty involved;
- Medical protocols made available upon request;
- All preadmission review programs providing for emergency admissions;
- Payor responsibility for obtaining precertification and concurrent review;
- Prompt responses to physician contacts required from UR programs;
- Where medical necessity is questioned, a physician may speak with physician of his or her specialty;
- Establishment of a reasonable target review period for each admission in which physician may not be contacted until the end of that period;
- Prohibition of UR incentive contracts for reduction of services; and
- Designation of a UR contact person by a physician.

We feel this legislation represents a major step in improving the third party review process for physicians and their patients, particularly in the areas of decision-making review and accountability, patient concern and the physician and staff time and resources necessary to comply with such review. (Please see MAG Council on Legislation Report for summary of legislative activity on HB 1813.)

Recommendations

1. That MAG continue its rigorous monitoring of the Medicare Part B operation in Georgia and stand firm in its support for laws and regulations which enhance the provision of medical care and the patient-physician relationship. *(Referred to Reference Committee B.)*
2. That MAG continue to communicate and inform physicians in a timely manner of the ongoing federal changes in the Medicare reimbursement system.
3. That MAG carefully monitor the implementation of HB 1813, the Utilization Review Regulation, in Georgia and inform physicians of their rights in this very important piece of legislation. *(Referred to Reference Committee B.)*
4. That MAG formally express its sincere gratitude to Dr. Joseph P. Bailey, Jr., for his sagacious and exceptional leadership of our efforts in meeting the Medicare dilemma in Georgia.
5. That MAG formally convey its appreciation to Thomas Anderson, Jr., M.D.; Anthony Castrini, M.D.; Frank Carlton, M.D.; Albert Carr, M.D.; Robert Copeland, M.D.; Charles Harrison, M.D.; Paul Jurgensen, M.D.; Joe Nettles, M.D.; James Van Buren, M.D.; and Donald Wright, M.D. for their energetic and tenacious activities on behalf of the medical profession in meeting the current Medicare dilemma.

HOUSE ACTION

Adopted Recommendations 2, 4, and 5 with highest commendation.

Attachment 1

MAG Calendar of Events

MAG Efforts in Medicare Crises (1988-1990)

June 28, 1988

AEtna signed contract becoming Medicare fiscal Intermediary in Georgia (annually renewable)

Implementation period (June 10, 1988 to December 31, 1988)

Operational period (January 1, 1989-September 30, 1989) October 1, 1989-September 30, 1990 (Prudential carrier dropped, reportedly because of decline in carrier performance reports)

September 28, 1988

HealthCare COMPARE Corporation signs contract with AEtna Life Insurance Company to become medical and utilization reviewer (similar contract period to AEtna, except allows for automatic renewal for two consecutive one year periods)

September-December 1988

MAG holds preliminary meetings with AEtna and HCC regarding conversion planning

November, 1988

MAG holds Medicare Educational Workshops with HCC representatives for physicians

January 1, 1989

AEtna begins official operational management of Medicare program

March 10, 1989

MAG President Nettles sends report to MAG physicians on Medicare difficulties and sets up MAG Medicare Hotline

March 23, 1989

Letter from Georgia Congressional delegation sent to Louis Hayes, HCFA Administrator, requesting investigation of AEtna Medicare

March 28, 1989

Georgia Medical Society, MAG and U.S. Representative Lindsay Thomas hold Medicare hearing in Savannah (over 250 physicians attend)

April 19, 1989

MAG statement on Medicare Conversion presented to Georgia Congressional Delegation and HCFA Director at hearing in Washington, DC

May 25, 1989

MAG leadership meets with AEtna and HCFA officials at the Savannah Medicare office

June 22, 1989

MAG leadership meets with AEtna and HCFA officials at the Savannah Medicare office

June-July, 1989

MAG Survey of Medicare Carrier Performance conducted

June, 1989

MAG initiates monthly Advisory Committee meetings with AEtna, HCFA, and HealthCare COMPARE

July 20, 1989

Monthly Advisory meeting at HCFA Regional Office in Atlanta

August 16, 1989

Monthly Advisory meeting in the Savannah Medicare office

August 30, 1989

Second Georgia Medical Society-MAG Hearing held in Savannah with Congressmen Lindsay Thomas and Roy Rowland; Barbara Gagle, Chief of HCFA Operations, and Georgia physicians (over 200 physicians attend)

Georgia Congressional Delegation requests General Accounting Office to conduct Medicare investigation in Georgia. GAO has agreed to do so with tentative date set for September, 1990

September 19, 1989

MAG leadership, Dr. Joe Nettles, Dr. Joe Bailey, and MAG and AMA staff meet in Washington with Barbara Gagle, Chief of HCFA Operations re: comprehensive service downcoding

September 20, 1989

Advisory group meeting at the Savannah Medicare office

October 18, 1989

Monthly Advisory meeting at the Medical College of Georgia in Augusta

November 10-22, 1989

MAG meets with Georgia Press on Medicare crisis

November 15, 1989

Monthly Advisory meeting in the Savannah Medicare office

November 24, 1989

AM NEWS article, "GAO to Probe Georgia Medicare Carrier in Wake of M.D. Complaints"

December 6, 1989

Secretary Sullivan requests study by Inspector General and HCFA of Georgia Medicare Program

AMA passes Georgia Delegation Resolution to change Medicare law on the "covering" physician

December 12, 1989

Members of Georgia Congressional delegation meet with HHS Secretary Louis B. Sullivan

December 13, 1989

Monthly Advisory meeting at the Medical Association of Georgia in Atlanta

December 29, 1989
Wall Street Journal article on Georgia Medicare problems

December, 1989
HCC officially changes comprehensive policy statement and documentation requirements allowing a more flexible interpretation.

January 16, 1990
Monthly Advisory meeting in the Savannah Medicare office

February 8, 1990
MAG publishes results of nationwide medical society survey on physician coverage by a colleague

February 15, 1990
Georgia Congressman Richard Ray holds Medicare Hearing in Warner Robins with local physicians, MAG, HCFA, and AEtna.

February 21, 1990
Monthly Advisory meeting at HCFA Regional Office in Atlanta

February 23, 1990
MAG staff meet with AMA staff in preparation for Congressional hearing

March 5, 1990
Represenative Henry Waxman, Chairman Subcommittee on Health and the Environment, and Congressman Roy Rowland hold hearing on Medicare problems in Georgia

March 16, 1990
MAG sends official response to HHS Inspector General's Report, "Beneficiary Satisfaction with Georgia's Medicare Carrier"

March 21, 1990
Monthly Advisory meeting in Savannah. MAG points out serious flaws in Physician Profile Data

March 26, 1990
U.S. General Accounting Office meets with MAG staff

April 18, 1990
Monthly Advisory meeting scheduled for Atlanta

Joseph P. Bailey, Jr., M.D. was the key individual representing MAG at every monthly advisory meeting. Other physicians who also contributed were Thomas Anderson, Frank Carlton, Albert Carr, Anthony Castrini, Charles Harrison, Paul Jurgensen, Joe Nettles, James Van Buren, and Donald Wright.

AD HOC COMMITTEE ON AIDS

Jack F. Menendez, M.D., Chairman

The Ad Hoc Committee on AIDS was established to develop and recommend AIDS policy guidelines. The Committee disseminated educational materials and programs for physicians and the public concerning the AIDS epidemic. The Committee met primarily in 1987, having studied all the materials that the American Medical Association had published, and numerous articles and publications from other organizations.

Our Committee consisted of representatives from the specialities of surgery, family medicine, pediatrics, pathology, psychiatry, internal medicine, and dermatology, as well as representatives from the Centers for Disease Control, the Georgia Hospital Association, the Department of Human Resources, the Auxiliary to the Medical Association of Georgia, the Mercer University School of Medicine, the Medical College of Georgia School of Medicine, the Morehouse College School of Medicine and the Georgia Task Force on AIDS. We worked closely with the legislature in 1988 to develop AIDS policy for the citizens of this state and were very successful in that regard.

Since that time, the AIDS Committee has not met, and I feel that the Committee has achieved its goal.

Recommendation

That the Ad Hoc Committee on AIDS be abolished.

HOUSE ACTION

Adopted.

PRO REVIEW COMMITTEE

Joe C. Stubbs, M.D., Chairman

I. Georgia Pro Activities

Attached is a summary of how the revised review system works. There are a number of other issues which the PRO Review Committee feels should be brought to your attention.

1. Changes in severity levels from 5 to 3 mandated by HCFA and the application of numeric values (point system) to these levels. Review the attachment for details as to how this works.

Letters have been revised to more clearly indicate their purpose. Physicians need to be cautioned to respond to the Preliminary Request for Additional Information in writing within the 30 day response time. If not, the quality issue cited will become the final determination with no opportunity for appeal after that time.

2. Quality of Care Denial — Over 3,000 responses were filed against the January 18, 1989 HCFA proposed rules to implement denial of payment for substandard care. Congress is currently revising the required language of the denial letters to eliminate specific reference to "substandard care." When changes are final, the quality of care

review system will be revised accordingly.

3. Invasive procedure review — with this contract the PRO is required, for every case under review, to determine if any invasive procedure performed (all surgical procedures and any other procedure which affects DRG assignment) was reasonable and medically necessary. The GMCF has drafted criteria (primarily adopted from Tennessee PRO criteria) which nurse coordinators are using for approval only. HCFA has indicated that these criteria are unsatisfactory. The GMCF will need more physicians to assist in this review and the further development of appropriate criteria. Physicians are encouraged to report any problems with review criteria to this Committee.

4. Preadmission/Preprocedure Review of the following 10 procedures is underway: Cataract Extraction; Carotid Endarterectomy; Coronary Artery Bypass with Graft; *Pacemaker Insertion; Percutaneous Transluminal Coronary Angioplasty; Complex Peripheral Revascularization; Hip Replacement; Laminectomy; *Hysterectomy and *Prostatectomy. (*procedures previously required prior approval).

5. Confidentiality issues continue to be a concern. A new effort is underway by HCFA to pressure PRO's into publishing data about their review activities. Your chairman has agreed to serve on a GMCF subcommittee to assure that whatever is published does not identify physicians and/or patients.

6. The GMCF has established two satellite offices in Tifton and Savannah to distribute the work load and make it easier for physicians to participate in the review process.

7. Three new physicians have been employed on a part-time basis to assist in the following PRO areas: Dan Burge, M.D. Quality Intervention Plan; John McClure, M.D., Invasive Procedure, Pre-certification and Ambulatory Care Review; and Joseph Hilsman, M.D., Physician Consultant Monitoring and PRO Relations. Also Asa Yancey, M.D., long time Medical Director at Grady Hospital, Atlanta, is now Medical Director of the GMCF Medicaid Precertification Program.

8. The Committee also considered 5 complaints related to these basic issues:

— multiple notices (at different times) relating to the same case. The review system does lend itself to the probability of this happening, i.e. letters relating to reimbursement issues (admission denial and DRG changes) are sent both to the physician and hospital; quality of care issues are directed only to the "source of the deficiency" (either the physician, hospital or both) by two separate departments of the GMCF.

— inadequate and/or erroneous review. With the number of people individually reviewing charts some errors and inadequacies are inevitable. However, these should not be consistent nor even frequent and should be brought to the attention of the Medical Director of the PRO immediately. The GMCF must correct these errors when they do occur.

— complaint about the length of delay for certification numbers for any of the ten procedures listed in number four in the above, performed as an emergency, e.g., coronary bypass surgery following failed angiography. Effective April 1, 1990, GMCF will be able to issue numbers for emergency procedures by telephone. Cases will still be subject to retroactive, post-payment full chart review.

II. Medicaid Precertification Program

You are no doubt aware that the Department of Medical Assistance (DMA/Medicaid) decided, in its infinite wisdom, to implement a precertification program for all elective inpatient and outpatient hospital procedures and admissions, when Medicaid is the primary payor. This was done, per Mr. Aaron Johnson, DMA Commissioner, in an effort to control the spiraling Medicaid costs in Georgia. This program became effective March 1, 1990.

In November 1989, the DMA contracted with the Georgia Medical Care Foundation to perform the certification review. It should be noted that this is not a PRO function. There is no concurrent care or quality of care review involved. Your chairman and MAG staff have been monitoring developments and responding to problems encountered by physicians.

The admitting physician is responsible for assuring that the appropriate clinical and demographic information is submitted with sufficient time to allow the review to function effectively. A summary of the policies, procedures and process is included in Attachment two.

Recommendations

1. That the function of this Committee be incorporated into the MAG Third Party Payors Committee.

2. That physicians be encouraged through announcements in MAG *Newsletter* and other membership communications to report to this Committee any problems with the criteria used for review or precertification.

HOUSE ACTION

Adopted Recommendations 1 and 2 with highest commendations.

Attachment 1

Summary of GMCF/PRO Review Process

1. For every case reviewed (case review is generated primarily by required review of X% of hospital billings) the GMCF is required to review for:

a. Coverage
b. Necessity of Admission/Appropriateness of Setting
c. DRG Validation
d. Appropriateness of Discharge
e. Quality of Care
f. Necessity of Invasive Procedures, if applicable.

(Note: Each hospitalization review stands alone. In 1989, the PRO reviewed approximately 15% of all Medicare hospital discharges.)

2. GMCF Review Coordinators (primarily RN's) use certain criteria and screens to review each chart e.g.

- Coverage — are services covered by Medicare as determined by HCFA Regulations? Unless there are extenuating medical circumstances, this decision is made by the fiscal intermediary/carriers.
- Intensity, Severity and Discharge (ISD) criteria address necessity of admission and contain specific indicators of the patients stability at discharge. These include "generic" and system-specific components.
- DRG Validation — reviewers look for the primary or principal diagnosis defined as "the condition, after study, that caused the admission."
- Quality of Care including appropriateness of discharge. Screens are applied to evaluate the quality of care received, the stability of the patient at discharge and to ensure the patient had adequate discharge planning.
- Necessity for invasive procedure review is a new requirement. Invasive Procedure Criteria is used to validate medical necessity and appropriateness of setting for all invasive procedures performed in Acute Care Facilities. Invasive procedures are all surgical procedures and any other procedures which affect DRG payment.

Review coordinators use these screens to abstract the entire medical record for screen failures or occurrences. They may determine that no problem exists but may not determine that a quality deficiency exists. If a potential problem is identified the case is referred to a physician consultant of the appropriate specialty and practice setting.

3. Physician consultants do respond to the specific issues raised by the review coordinator. Determinations relating to necessity of admission, utilization issues and DRG validation involve reimbursement. Therefore these notices are sent to the physician and hospital with an option to respond within 20 days as specified by law. Once a final determination is made, notices go to the physician, hospital, and beneficiary. Either party can file a request for reconsideration within 60 days.

Physician consultants are further required to review the complete chart using their medical judgment to identify potential quality deficiencies, determine the source of the deficiencies and assign preliminary severity levels. For confidentiality reasons, notices relating to quality of care issues are directed only to the "source of the deficiency" which may be the physician, hospital or combination.

Severity levels are mandated in accordance with Health Care Financing Administration (HCFA) definitions and are as follows: (revised from 5 levels used by GMCF)

Level I — Confirmed quality problem *without the potential* for significant adverse effects on patient.

Level II — Confirmed quality problems *with the potential* for significant adverse effects on the patient.

Level III — Confirmed quality problem *with significant* adverse effect on patient.

Significant adverse effect is defined as (1) unnecessarily prolonged treatment, complications or readmissions; and/or (2) anatomical or physiological impairment.

The responsible physician and/or provider is notified by way of a Preliminary Request for Additional Information of the potential quality problems and offered an opportunity to respond in writing. Only written response received within the designated time frame (30 days) will be used prior to the initiation of a Final Quality Determination Notification. Therefore, physicians are encouraged to respond as it will prompt a second physician's review of the case. In the absence of additional information, the initial determination will be upheld without further review.

On receipt of the written additional information, the case is reviewed by a second Physician Consultant of the same specialty and practice setting. GMCF will make a final determination based on all information available at the point of final review by the second Physician Consultant.

GMCF will issue a Final Quality Determination Notification to the responsible party involved indicating confirmation of a quality problem or appropriate care. If a quality problem is confirmed, this notice will include (1) a description of the problem, (2) a suggested alternative course of action (Note: This is a new requirement with this year's contract) and (3) the severity level. Since quality determinations are not

denials of reimbursement (at this time), there is no reconsideration or appeal process for reversal of the severity level once it is assigned. Further action is dependent on the Quality Intervention process.

4. Quality Intervention:

Final Quality Determination Notifications are issued on confirmed quality problems and are evaluated for intervention during profiling, and activity which occurs quarterly.

As a part of the profiling exercise, HCFA mandated numeric values are assigned to each quality problem based upon its severity level. (Level I = 1; Level II = 5; Level III = 25).

It is important to understand that the weighted severity score is merely an internal PRO mechanism to identify physicians and providers whose cases require further review by an intervention committee. Decisions and actions are not based upon the weighted severity score. The total weighted severity score serves as a guide for considering appropriate forms of intervention. Actual interventions are decided on a case by case basis.

These confirmed quality of care problems are reviewed and evaluated by three practicing physician member Intervention Committees to determine the appropriate intervention to be implemented.

Based on the points accumulated, one or more of a hierarchy of HCFA mandated corrective interventions are considered:

— Notification
— Education
— Intensified review
— Other interventions
— Coordination with licensing bodies
— Initiation of a sanction recommendation

Notification: Occurs if three or more points are reached in quarter. The purpose is to make the responsible party aware of peer oversight and to encourage self-assessment.

Education: Occurs if ten points are reached within quarter. The education requirements will be problem specific. It may simply involve sharing of material or references from the scientific literature or in some cases, the completion of a CME course or other intervention may be expected.

Intensification: Occurs if fifteen or more points are reached within a quarter. The purpose of intensified review is to determine if problems similar to those previously identified have occurred. The level of intensification is a temporary step leading either to more substantial interventions or to resolution.

Other Interventions: Occur if twenty or more points are reached within a quarter or if a committee has other significant concerns. (1) Referral to the appropriate hospital committee; (2) mandatory consultations relative to specific illnesses and/or (3) pre-discharge review of identified subsets as applicable are examples of possible interventions.

Coordination with Licensing Bodies/Sanction Process Initiated: This action is considered if twenty-five or more points are reached in a quarter or if the Interventions Committee has other significant concerns.

5. Sanctions:

A. GMCF

Sanction recommendations to the Office of the Inspector General are reserved for those situations where the GMCF Executive Committee determines that a practitioner or provider poses IMMINENT RISK to the health of Medicare beneficiaries and/or demonstrates an UNWILLINGNESS OR INABILITY to comply with statutory obligations.

Section 1156 of the Social Security Act imposes the following obligations upon those who provide services under Medicare. That services are:

1. provided economically and only when, and to the extent, they are medically necessary;
2. of a quality that meets professionally recognized standards of health care; and
3. supported by the appropriate evidence of medical necessity and quality of the services in a form and fashion as may be required (documented completely at each hospitalization)

Should the Intervention Committee decide to initiate the sanction process rather than proceed with the other identified interventions, an *Initial Sanction Notice* is directed to the involved party after the committee determines that the practitioner:

— failed in a substantial number of cases to substantially comply with any obligation imposed under Section 1156 of the Act; or

— grossly and flagrantly violated any such obligation in one or more instances.

The distinction is important because gross and flagrant violations may pose imminent danger to patients and because of the differences in notice requirements.

The provider or practitioner is entitled to 2 *Notices* and 2 *Opportunities* to submit additional information and/or meet with the GMCF Medical Review Committee to discuss an allegation of *Substantial Violation in a Substantial Number of Cases.*

With an allegation of *"Gross and Flagrant Violation,"* the provider is entitled to *One Notice and One Opportunity* to submit additional information and/or meet with a Medical Review Committee.

Based on the review of the additional information, the Medical Review Committee will make its determination. If a recommendation to sanction is made, it is reviewed by the GMCF Executive Committee prior to issuing the *Final Sanction Notice.*

A copy is also directed to the Office of Inspector General (OIG) for disposition.

One of two sanctions may be imposed:

— A monetary penalty for no more than the "actual or estimated cost of the medically improper or unnecessary service so provided," or

— Exclusion from the Medicare program for a specified period of time.

B. Office of Inspector General

If GMCF recommends a sanction, the involved party has 30 days to submit additional documentation to the OIG.

The OIG may accept, reject or modify the sanction recommendation forwarded by the PRO.

If accepted, the physician or provider may appeal the sanction to an Administrative Law Judge.

If dissatisfied with that appeal, the sanctioned party may appeal to the Secretary's Appeal Council and may thereafter seek judicial review in court.

Attachment 2

Georgia Medical Care Foundation Department of Medical Assistance (Medicaid)

Precertification Review Policies and Procedures

I. Admissions Subject to Review

This program covers both elective and emergency admissions. Precertification also is required for certain CPT-4/HCPCS procedures. Providers should refer to the definitions below in deciding when to obtain authorization numbers. Requests for elective admissions and procedures must be made prior to the planned date. Requests involving emergency admissions or procedures must be made within two working days following the date of the admission or procedure.

"Emergency Admission or Procedure" is defined as any admission or procedure occurring as a result of a condition which, if not treated within 48 hours, would result in significant deterioration in the recipient's health status.

"Elective Admission or Procedure" is defined as any non-emergency admission or procedure which is medically necessary and is covered by DMA (i.e. excludes experimental procedures, cosmetic procedures or other non-covered procedures).

II. Admission/Procedures Not Subject to Review

- Admissions and procedures for which Medicare (Part A) is the primary payor.
- Normal deliveries.
- Admissions of, or procedures performed on, infants less than one year of age.
- Procedures performed in the physician's office.
- Admissions and procedures for non-enrolled and non-participation providers.
- Emergency room services.

III. The Review Process

The attending or admitting physician, podiatrist or other practitioner is responsible for obtaining the precertification number. Requests should be initiated at least one (1) week prior to planned admission or procedure. Requests for precertification may be transmitted by phone, mail, FAX or modem to GMCF beginning *February 19, 1990.* Written notice of the decision will be sent to the requester within one working day of the decision. To obtain precertification, the practitioner or qualified office personnel or hospital may contact GMCF as described below:

Mailing Address:
Georgia Medical Care Foundation
Medicaid Precertification Program
PO Box 49049
Atlanta, Georgia 30359

Telephone: For Precertification Call: 1-800-942-4623; For Provider Service Call: 1-800-942-4621. (When calling from Atlanta, be sure to use the 800 number)

Modem: Please call the provider service number to register for this service. A packet of information will be mailed to you.

NOTE: Phone and modem are available Monday-Friday, 8:00 a.m.-6:00 p.m.

FAX: 1-404-728-7593 (Available 24 hours)

Providers may order precertification forms by writing to the mailing address or by calling the provider service number listed above. A sample form is included herewith.

When calling for a precertification number, it would be wise to complete one of these forms for each precertification required. That way, you will be sure to have the information needed to complete the process with one phone call.

The Medical Review Specialists (RNs) will record the data and review the diagnosis and symptoms against a pre-established set of admission criteria during the initial call. If the admission is approved, a six (6) digit authorization number is immediately given over the phone. GMCF will send a written approval notice to the requester within one working day of the final decision. The practitioner must provide this number to the admitting hospital and other providers and record it in the patient's medical record.

The approval is valid for 90 days from the date of issuance. If the re-

cipient has not been admitted or the procedure has not been performed during this time period, another request to GMCF must be made to obtain a new number.

Note: *Approval of an admission or procedure only confirms the need for services to be provided. It does not guarantee payment or determine that the recipient is Medicaid eligible.*

IV. Denials

In the event the admission or procedure(s) cannot be approved by the GMCF Review Specialist, it will be referred to a physician consultant for review. The physician consultant may telephone the requesting party for additional information and to discuss the case details. An attempt will be made to reach agreement on the case whenever possible.

If a negative determination is reached, the requesting party will be notified in writing of the decision and the rationale for it. No authorization number will be issued and no reimbursement will be allowed to either the physician or the hospital if the patient is admitted or the procedure is performed.

V. Appeals

Reconsideration of denials may be requested in writing within ten calendar days of receipt of GMCF's denial letter. These may be filed by the requesting practitioner, the hospital, ASC or the recipient.

These requests should be addressed to:

The Georgia Medical Care Foundation
Medicaid Precertification (Reconsideration)
PO Box 49049
Atlanta, Georgia 30359

Reconsideration reviews are conducted by a physician consultant that the one who conducted the original review.

VI. Prior Approval and Mandatory Outpatient Review

GMCF will be assuming responsibility for issuing precertification numbers for procedures currently included in the DMA prior approval listing (request this list from GMCF if you did not receive it in their March 1990 mailing) and mandatory outpatient listing. Providers should contact GMCF to obtain precertification when one of these procedures is planned. If a precertification number has been obtained for an admission or procedure which is not on this and the practitioner now wants to perform one of the prior approval procedures, the practitioner must contact the GMCF to request approval before performing the procedure(s). Failure to obtain specific approval for these procedures will result in denial of payment. The GMCF precertification number will replace the existing prior approval number. All other DMA policies involving these procedures will remain in force.

VII. Inquiries About Precertification Review

Inquiries regarding this program should be directed to the Georgia Medical Care Foundation at 1-800-942-4621. Please do not use this number to request precertification.

VIII. Claims Submission

When submitting claims that require precertification, providers must include the authorized number in the appropriate space on the claim form as follows:

- UB82 (Inpatient or outpatient use location 91)
- HCFA-1500 (Physicians, podiatrists, ASC, and other practitioners) Use the "prior approval/authorization numbers" block.

VIV. Day-To-Day Work Plan

The Medicaid Precertification day to day work plan is as follows:

15 Registered Nurse Review Coordinators on incoming lines.

2 Referral Coordinators will:

- Handle all referrals for team
- Assist with team problems/questions
- Handle call backs for team

1 Mail/FAX Coordinator will: (Monitoring Station)

- Monitor 15 incoming lines and assign telephone messages to call back staff
- Oversee, assign and follow-up on FAX/mail-in process, and DMA medical and dental prior approval for entering and call back phones, ABC
- Answer provider line
- Assist referral coordinator as needed
- Coordinate precertification for large provider, i.e., Grady or Eggleston

3 Review Coordinators on Outgoing Lines

This is a total of 21 Registered Nurses all of which will be cross-trained for both incoming and call back positions.

RESOLUTION 6

MAG Committee on Scientific Assembly

Roland S. Summers, M.D.
Hillary R. Newland, M.D.
William E. Silver, M.D.
Carl L. Rosengart, M.D.
Rodney L. Smith, M.D.

Whereas, the Medical Association of Georgia House of Delegates in 1973 approved the creation of a fall multi-specialty MAG scientific meeting to be held in Atlanta; and

Whereas, this MAG Scientific Assembly has been held annually since 1975, with continuing medical education programs planned by participating specialty societies; and

Whereas, a Committee on Scientific Assembly was created in 1975 to monitor these activities, and was made a Standing Committee of the Association by the House of Delegates in 1977; and

Whereas, the MAG Continuing Education (CME) Committee is authorized to grant American Medical Association Category 1 credit for the Scientific Assembly; and

Whereas, the Scientific Assembly Committee must submit all specialty CME programs to the MAG Continuing Medical Education Committee for approval and AMA Category 1 credit; and

Whereas, this procedure of two MAG Committees working on the same project has proven difficult and ineffective; and

Whereas, the national continuing medical education accrediting authority, ACCME (Accreditation Council for Continuing Medical Education), has called on MAG "to revise the composition of committees which deal with CME in order to simplify the chain of command"; now, therefore be it

RESOLVED, that the Scientific Assembly and Continuing Medical Education Committees shall be merged into a special committee of the Association, entitled "Committee on Continuing Medical Education and Scientific Assembly"; and be it further

RESOLVED, that Chapter X, Section 1 of the Bylaws be amended by the deletion of line "(G) Committee on Scientific Assembly," and the substitution of "(G)" for "(H)", so that when amended the Section will read: "SECTION 1. *Standing Committees*. The standing committees of the Association shall be as follows: (A) Executive Committee of the Board of Directors; (B) Committee on Finance; (C) Judicial Council; (D) Committee on Auxiliary; (E) Committee on Constitution and Bylaws; (F) Committee on Annual Session; (G) Committee on Publications," and be it further

RESOLVED, that Chapter X, Section 8, "COMMITTEE ON SCIENTIFIC ASSEMBLY" be deleted and that Section 9 be renumbered to read "SECTION 8. *COMMITTEE ON PUBLICATIONS.*"

Referred to Reference Committee on Constitution and Bylaws.)

HOUSE ACTION

Adopted the first RESOLVED portion.

RESOLUTION 7

Medical Support for 1996 Olympics

DeKalb Medical Society, Inc.

Whereas, there is a reasonable possibility that the 1996 Olympics will be held in Atlanta; and

Whereas, the MAG wholeheartedly endorses and supports all efforts to bring the 1996 Olympics to Atlanta; and

Whereas, there will be a tremendous need for health care support due to the large crowds and the many competitive athletes involved; and

Whereas, the Medical Association of Georgia, through its enormous pool of potential volunteers, is in an excellent position to coordinate the health care for the Olympics; now, therefore be it

RESOLVED, that the Medical Association of Georgia offer to serve as the coordinating agency for all health care during the Olympics if Atlanta is chosen as the 1996 site; and be it further

RESOLVED, that MAG immediately express its enthusiastic support of the entire project and offer its assistance and the support and participation of its volunteers.

HOUSE ACTION

Adopted the first RESOLVED as amended: "That the Medical Association of Georgia offer to serve as a cooperating agency for all health care during the Olympics if Atlanta is chosen as the 1996 site."

Adopted the second RESOLVED.

RESOLUTION 16

AMA Membership for MAG Officers

David J. Frolich, M.D.

Whereas, the voice of organized medicine begins with county medical societies, who elect officers through their delegates to their state association, who then use the same process in electing AMA officers; and

Whereas, Georgia has a unified membership with state and county medical societies; and

Whereas, the House of Delegates of the Medical Association of Georgia has clearly rejected, on numerous occasions, a unified membership with the American Medical Association, but MAG's leadership has always stressed during these debates the desirability of AMA membership; and

Whereas, many proposals which come from the MAG House of Delegates are referred to the American Medical Association for further action; and

Whereas, in order to set an example for all members of MAG; now, therefore be it

RESOLVED, that all officers, directors, alternate directors, and delegates of the Medical Association of Georgia be required as a condition of holding such office to be a member of the American Medical Association.

HOUSE ACTION

Did not adopt.

RESOLUTION 32

MAG Roster

Charles R. Underwood, M.D.

Whereas, the 1990 Roster is being expanded to include more information about the Medical Association of Georgia and its members in compliance with action of the 1989 House of Delegates' Resolution 33; and

Whereas, one of the goals for expanding and improving the Roster is to use it as a marketing tool to increase advertising income; and

Whereas, the 1989 MAG House of Delegates articulated that it does not want personal demographic information made available to advertisers or other persons or organizations outside the Association; now, therefore be it

RESOLVED, that the personal demographic information be printed as a separate section within the new MAG Roster and that two versions of the Roster be printed: one with the personal information section included and which would be available only to MAG members and staff, and a second version excluding this personal information section, which would be available to advertisers.

HOUSE ACTION

Adopted and added the following recommendation: "That the MAG Board of Directors study the advisability of continuing publication of the Roster in the expanded format."

RESOLUTION 35

AMA Executive Vice President

Cobb County Medical Society

Whereas, the American Medical Association, following the resignation of Dr. James Sammons, is currently involved in a search for a new Executive Vice President; and

Whereas, the image and perception of the AMA has been brought into question by the events surrounding business transactions related to the administration of Dr. Sammons; and

Whereas, the AMA is an organization concerned not only with health affairs but also is involved with the pursuit of numerous financial objectives; now, therefore be it

RESOLVED, that the MAG Delegation to the AMA House of Delegates be directed to encouarge individuals representing the AMA on the current search committee for a new Executive Vice President to carefully consider the placement of an individual, not necessarily a physician, selected from the business world who might more efficiently administer the organization both from a medical and business viewpoint.

HOUSE ACTION

Adopted.

RESOLUTION 54

Bicycle Safety Helmets

Medical Association of Atlanta

Whereas, there are now 110 million bicycles in the United States and 85 million Americans who ride bicycles for recreation; and

Whereas, over 1300 deaths and 600,000 emergency room visits result from bike riding accidents each year; and

Whereas, bicycle safety helmets are extremely effective in preventing head injury; and

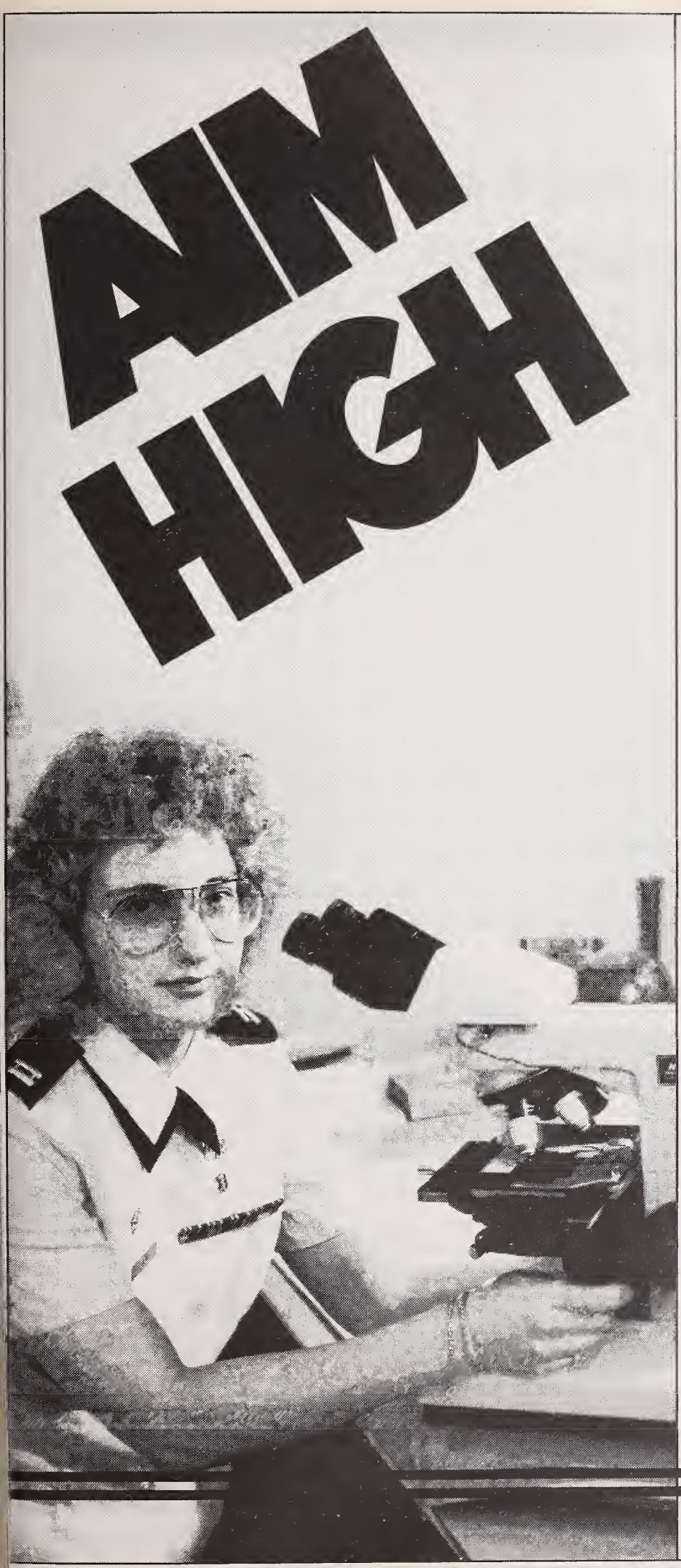
Whereas, helmets are extremely important for children, who suffer the majority of serious head injuries from bicycling accidents; now, therefore be it

RESOLVED, that the Medical Association of Georgia develop material for distribution through public and private school systems to educate children concerning bike safety; and develop public service announcements for television and radio to educate children and their parents regarding the need to purchase and use bike safety helmts; and be it further

RESOLVED, that the Medical Association of Georgia ask insurance companies and other public spirited Georgia corporations and public safety departments to participate in this project.

HOUSE ACTION

Referred to the MAG Public Relations Committee.



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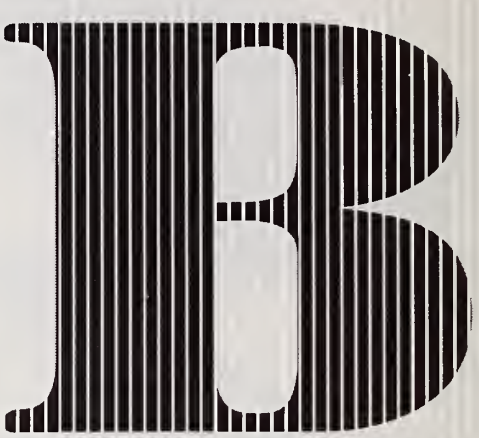
AIR FORCE

Report of Reference Committee B



Reference Committee B was comprised of the following physicians: Alexander H.S. Weaver, Jr., Chairman, Bibb; Luther M. Thomas, Jr., Vice-Chairman, Richmond; Roland S. Summers, Georgia Medical; Robert Glenn Carter, St. John's Parish; Rodney L. Smith, Hall; Alva L. Mayes, Jr., Bibb; Frank E. Carlton, Georgia Medical; Jeffrey T. Nugent, Medical Association of Atlanta; Irving D. Hellenga, Stephens-Rabun. MAG Staff: Cam Taylor, Director of Medical Practice.

OFFICE OF THE PRESIDENT

Joe L. Nettles, M.D.

The events of the past year have been considerable in both scope and depth. We have faced many problems and still have many before us. As the old cliche goes, "There is good news and there is bad news." First the good news.

1. *Membership Expansion:* Due to both the many problems facing medicine at this time and the hard work of staff and the Membership Expansion and Involvement Committee, we have grown to a membership of 7225, which represents a net gain of 303 over the past year. I am delighted that MAG has over 75% of its members also as AMA members. This entitles us to another delegate and alternate delegate to the AMA!

2. *Long-range Planning:* Under guidance of our President-Elect, the Executive Committee met with leaders from specialty societies, and from local and district societies. Questionnaires were sent to all our membership regarding the mission, goals and shortcomings of our organization. We believe we are now in a better position to plan for our future.

3. *AEtna, HealthCare COMPARE:* This issue has consumed the bulk of the energies of MAG staff and leadership, and well it should. No other issue has so affected the practice of all MAG members. The inefficiencies of AEtna and the designed interference of HealthCare COMPARE have made medical practice, especially by the primary specialties, so difficult that many physicians have been forced to modify their practice or terminate practice altogether. More than that, it is the patient who suffers most. Through the persistent efforts of MAG staff and physicians throughout the State, these inadequacies have been recognized, not only in this State, but throughout the nation. The convening of a recent Congressional Subcommittee hearing attests to the gravity of the problem. We still have a long way to go toward recognizing and achieving the solution.

4. *Legislative:* The major goal of this year's legislative effort was to obtain relief for the dwindling number of practicing obstetricians in this

State. Although we had an impressive victory in the Senate, the Speaker buried the Arbitration Bill in the House. Although this was lost, we were successful in having formed a Governor's Blue Ribbon Obstetrical Crisis Commission to recommend solutions to the 1991 General Assembly. The remaining actions of the Session were favorable toward quality medical care, thanks to much effort from our Legislative Staff, our Auxiliary and many concerned physicians.

5. *Staff Harmony:* After a turbulent preceding year, we now have an able, efficient and harmonious Medical Association staff. Credit is to be given both to our Executive Director and to every staff person who has worked so hard to implement our goals.

6. *Savannah Obstetricians:* The Justice Department, acting on the request of the Federal Trade Commission, has been investigating a complaint of alleged price-fixing on the part of all 31 Savannah obstetricians in a response to a business coalition inquiry over 5 years ago. A Federal Grand Jury was convened and has met for over a year. This has put those thirty-one obstetricians through a living hell. MAG, with aid from AMA, has employed the best legal experts on such matters, in cooperation with each physician's individual attorney, to prepare a joint defense to be used in event of an indictment being sought. We have now learned that the Grand Jury has been disbanded and that no criminal indictment will be sought. Unfortunately, the Justice Department is still considering civil remedies.

7. *Treasury:* All of the above activities, especially the efforts to cope with Medicare problems, necessitating repeated trips to Washington, as well as extra all member mailings, have required extra expenses that were not budgeted. However, through astute cost-cutting measures elsewhere, it appears that we will not require a dues increase at this time.

8. *Auxiliary:* Once again our Auxiliary has worked tirelessly with a variety of worthwhile projects throughout the state. They have also cooperated with staff and the Executive Committee in every way, especially in our legislative efforts. Grace Walden and all our spouses deserve our deepest gratitude.

Now for the bad news — we still face unresolved problems.

1. *AEtna, HealthCare COMPARE:* HCFA and Congress may feel that all of the complaints from the doctors of Georgia are an indication that AEtna and HealthCare COMPARE are doing a good job as far as cost saving measures are concerned. We must continue to point out that the patients of Georgia are the real losers in this process.

2. *Physician Care Program:* Thus far we have been fortunate in staving off attempts in the past two legislative Sessions to mandate acceptance of assignment both for Medicare and Medicaid. However, if we do not push forward with an active program to demonstrate to the people of this State that they will always have access to good affordable health care, we will find ourselves in the deplorable position of Massachusetts and other such states where mandatory assignment has resulted in a wholesale exodus of physicians from the State. At this point, less than 15% of our membership have made a positive response to our survey soliciting aid in the Physician Care Program. This is hardly a mandate with which to push forward. Yet, we have always taken care of our population's health needs and we must continue to do so.

3. *Obstetrical Relief:* During the past 10 years, the number of physicians delivering babies has dwindled significantly. There are now ninety-six counties in Georgia with no physician delivering obstetrical service. We must double our efforts to relieve this crisis.

Recommendations

1. MAG through the combined efforts of the Ad Hoc Committee on Citizens Advocacy, and the Public Relations Committee launch a positive program to insure that the health care needs of all the citizens of Georgia are met, utilizing the successful efforts of South Carolina or Kentucky as a model.

2. MAG continue an all out effort to insure that good obstetrical care is available throughout Georgia. *(Referred to Reference Committee C.)*

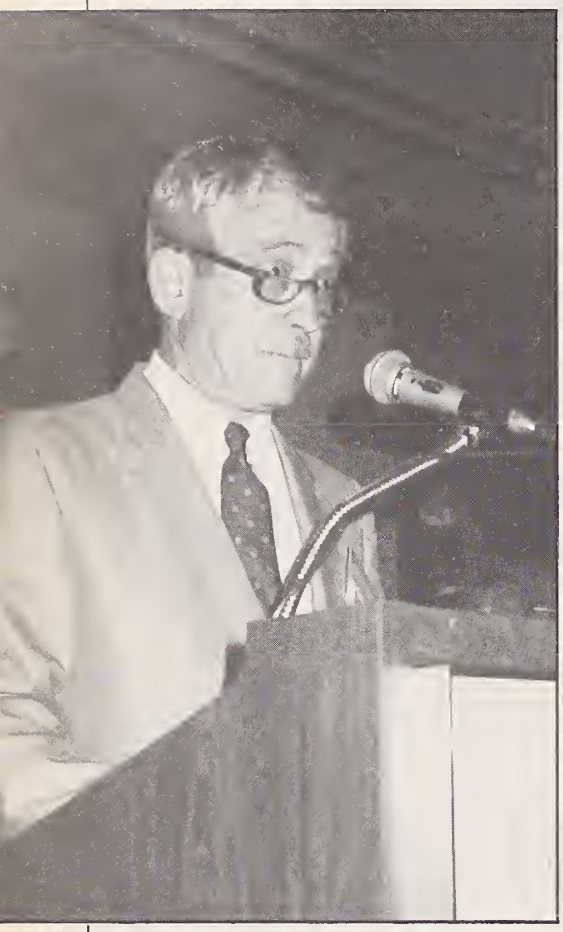
HOUSE ACTION

Adopted Recommendation 1 as amended: "That MAG, through the combined efforts of the Ad Hoc Committee on Citizens Advocacy and the Public Relations Committee, launch a positive program to insure that the health care needs of all the citizens of Georgia are met, utilizing the successful efforts of other states."

REPORT OF THE SECRETARY

Ralph A. Tillman, M.D.

During the 1985 session of the Georgia General Assembly, I was informed that after serving the first year of a three year term, Dr. John Yauger had found it necessary to resign as Secretary of the Medical Association of Georgia. With just a little encouragement I decided to run for that office, and now, five years later, I find that my only regret is in not having become more in-



Reference Committee B Chairman Alexander H.S. Weaver, Jr., M.D., of Bibb County, reports the actions and recommendations of his Committee to the House of Delegates.

volved at a much younger age. These five years have been filled with many challenges, opportunities, much frustration, and untold hours spent with remarkably dedicated members of the medical profession in an attempt to meet the challenges before us in a manner acceptable to the majority of our members. Often, that constituency expanded to include those physicians who, for whatever reason, have chosen not to be members of their local society, the Medical Association of Georgia and/or the American Medical Association.

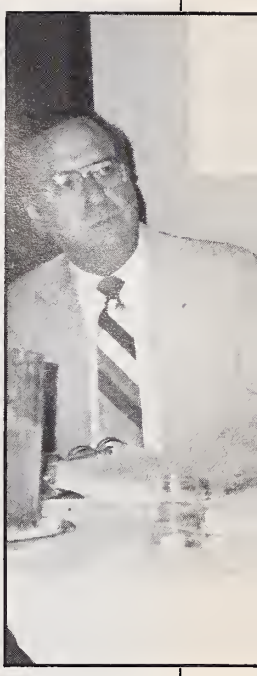
It is with great pride, pleasure and satisfaction that, as I reflect on the major decisions that I have been involved with, not once can I recall an instance wherein a decision was made purely and simply on the basis of what is "best for medicine" (well . . . perhaps once, but I'll not get into that). I believe that the majority of our members would like for the Medical Association of Georgia and the American Medical Association to serve as advocates for the patient — rather than as self-serving organizations. Those of you who have been involved in the affairs of the Medical Association of Georgia know that there have been times when I aggressively opposed proposals with which I disagreed. I would hope, however, that most of you believe my decisions were always based on what I perceive to be in the best interest of the recipients of our care.

I have many fond memories of having served you as Secretary of the Medical Association of Georgia — under the able leadership of Drs. Logan, Watson, Menendez, Bailey, and Nettles who served as Presidents of the Medical Association of Georgia during those years. I look forward to working with and serving you as an alternate delegate to the American Medical Association. At this moment, I have not entirely closed the door on considering serving you and the medical profession in other capacities, as well.

Although I cannot imagine that the practice of medicine in the Nineties will be nearly as much fun, as satisfying or as pleasurable as it has been over the past thirty years, permit me to leave you with a few strong personal impressions:

— The House of Medicine will continue to be the target of attacks by interests that we are all very much aware of: various consumer groups, bureaucratic agencies (both state and federal), third party payors, alternative health care entrepreneurs, the legal profession, health care providers who wish to be granted the privilege to practice medicine without the necessity of going to medical school, and others.
— The medico-legal atmosphere is apt to get even worse than it is now.
— Significant tort reform efforts on a state level will continue to be futile, and premiums in a year or two will probably begin to escalate again.
— Ultimately, societal attitudes will change and pressure brought to bear on the national level to develop means wherein injured parties can be properly compensated without the stressful climate encountered in the courtroom. Increasingly, we will turn to alternative dispute resolution mechanisms, binding arbitration, or some system similar to workers' compensation.
— Efforts on the part of organized medicine to overcome all of these onerous forces are not very likely to succeed.

In preparation for our battles ahead, I hope that we will intensify our efforts as advocates for our patients — for without the support and cooperation of our patients, we may well be consumed by a movement most of us abhor — *National Health Care!*



Members of Reference Committee B are (L to R): Irving D. Hellenga, M.D., Stephens-Rabun; Rodney L. Smith, M.D., Hall; Robert Glenn Carter, M.D., St. John's Parish; Roland S. Summers, M.D., Georgia Medical Society; and Alva L. Mayes, Jr., M.D., Bibb.

Recommendation

Charge the Long-Range Planning and Development Committee with developing ways for physicians to overcome the agonizing necessity of practicing defensive medicine, by developing a strong offensive effort with the goal of salvaging some semblance of freedom-of-choice, fee-for-service, private practice of medicine.

HOUSE ACTION

Adopted recommendation as amended: "That MAG charge the Long Range Planning Committee to develop ways for physicians to overcome the agonizing necessity of always being on the defensive by developing a strong offensive effort with the goal of salvaging freedom-of-choice, fee-for-service, private practice of medicine."

Membership Comparison

	1989	*1988*	*1987*	*1986*	*1985*
Active	5526	5421	5351	5201	5056
Active Resident	242	365	538	376	357
Affiliate	4	7	7	7	7
Associate	40	52	64	58	62
DE-1 (financial hardship/illness)	63	59	58	54	48
DE-2 (post-grad training)	2	2	2	2	2
DE-4 (temporary military)	1	1	2	2	2
DE-4 (life)	366	349	325	262	257
DE-7 (over 70)	59	58	35	89	87
Retired	398	364	325	304	241
Service	41	36	52	56	62
Student	233	208	141	93	50
	6975	6922	6900	6504	6231
AMA MEMBERSHIP	3619	3457	3403	3289	3416

*The above AMA membership figures reflect only those AMA members who pay AMA dues via MAG

ACCESS TO MEDICAL CARE COMMITTEE

M. Julian Duttera, Jr., M.D., Chairman

The last 10 years has seen the growth of a number of efforts to place physicians in rural Georgia: the Medical Fair; the Joint Board of Family Practice Placement Service; the Medical Education Board Scholarship program and the newly developed Loan Repayment Plan. Of these four efforts directed toward placing physicians in rural areas, only one existed 10 years ago. We still have far to go.

Recent studies refute the physician surplus indicated by the Graduate Medical Education National Advisory Committee (GMENAC) study. Compared to the 1990 GMENAC standard of 191.4 physicians per 100,000 population, the 1986 Board of Medical Examiners survey of Georgia reflects the following:

Category	1986 #	Rate*
County Population		
0- 9,999	98	38.0
10,000- 19,999	382	51.0
20,000- 49,999	965	75.0
50,000-149,999	1,405	127.0
Over 150,000	6,024	227.0
State Total*	8,975	148.0
Metropolitan Statistical Area	7,014	183.0
Non-MSA	1,860	84.0

(*Rate per 100,000 rounded to nearest whole number)

Obviously, there remains a maldistribution problem. There has been no apparent spill over from metropolitan to rural areas. In addition, the decline in medical school applicants is becoming a major concern in our efforts to assure the availability of physicians throughout the state.

1. Medical Fair

The Medical Fair, begun by MAG in 1978, continues to expand in sponsorship and effectiveness. It has contributed to placing 181 physicians in Georgia. Other states continue to copy the concept of on-site recruitment/placement opportunities for physicians for small communities. In 1990, the Medical Fair will be held at the Waverly Hotel, Atlanta, Georgia, September 28-29. You are encouraged to stop by to see how this program has advanced.

2. Joint Board of Family Practice

Although the Joint Board was established to develop family practice residencies in Georgia, its placement assistance has evolved into a non-profit, community-to-physician match placement service for all specialities. It is not limited to small communities. In fiscal year 1988-89, it made 12,223 referrals and placed 68 physicians. Approximately 63% of physicians placed were family physicians, and most of these were placed in small communities. Currently 162 physicians and 92 opportunities are registered. The program is basically a two-person shop operated at no cost to participants. The Joint Board hopes to have the placement service written into Georgia law to assure its continuity and growth.

In December 1989, the Joint Board published a study entitled *Quality of Life and the Distribution of Physicians in Georgia: A Disturbing Paradox.* This study analyzes relationships between recognized quality of life variables and physician location. Your Committee plans to review this document further.

The Joint Board also supports 7 residency programs with funds allocated for 129 residents. An additional residency program was approved this year.

3. State Medical Education Board

In addition to serving as the principal coordinator of the Medical Fair, the Medical Education Board funds approximately 30 education scholarships. Applicants are expected to go into primary care and meet their obligation by practicing in underserved areas. The Board requires a triple indemnity refund if these obligations are not met.

4. Loan Repayment Program

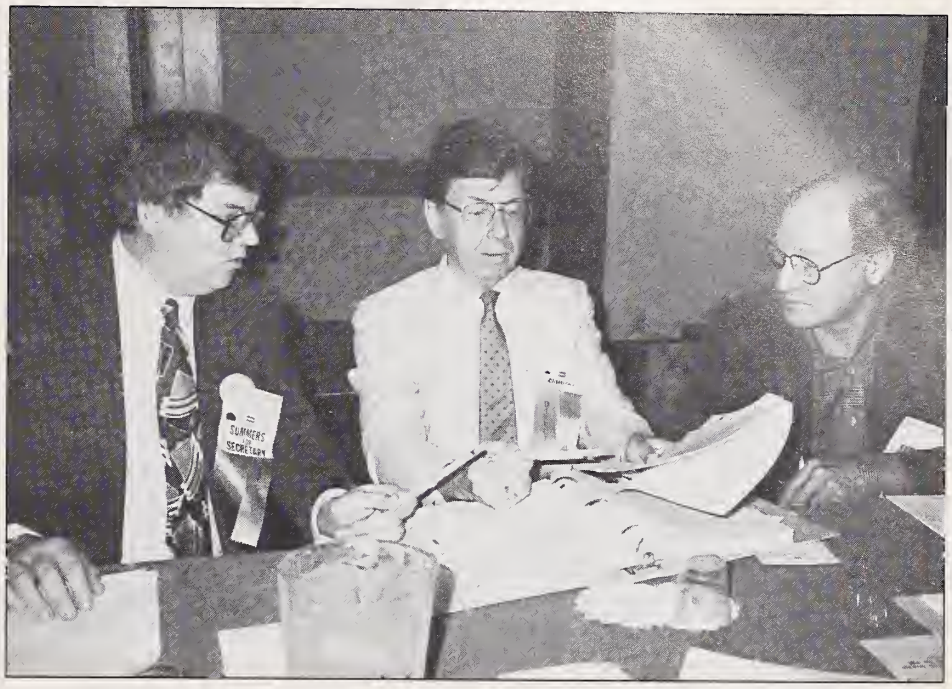
The State Medical Education Board "Physicians for Rural Areas Assistance Act" was established in 1989 by the Georgia General Assembly to "increase the number of physicians in physician underserved rural areas of Georgia by making loans to young physicians who have recently completed their medical education, and allowing such medical education loans to be repaid by such physicians agreeing to practice medicine in such rural area."

Those primary care physicians with a degree in allopathic (M.D.) or osteopathic (D.O.) medicine who have completed or who are in their final year of an approved graduate program in allopathic or osteopathic medicine in the United States and who have a license to practice allopathic or osteopathic medicine in Georgia may apply.

To be considered for a loan, each applicant must document outstanding medical education debt and commit to practice in a physician underserved rural area within the State of Georgia. These physician underserved rural areas are determined by the Board with the assistance of several state and private agencies. The name and location of the practice areas are available upon request.

Priority is given to those applicants who are specializing in OB/GYN, Family Practice, General Practice, General Internal Medicine, General Pediatrics, General Surgery, Psychiatry, or other medical specialties approved by the Board.

This program was funded at $50,000 in both 1989 and 1990. A physician recruitment seminar was conducted August 24, 1989. As a result three physicians have been placed; one each in Hancock, Johnson, and Turner counties. Another recruitment seminar is being conducted by SMEB in Albany, May 2, 1990.



Conferring on the business of their Reference Committee B are (L to R): Jeffrey T. Nugent, M.D., Medical Assn. of Atlanta; Luther M. Thomas, Jr., M.D., Vice Chairman, Richmond; and Frank E. Carlton, M.D., Georgia Medical Society.

5. Changes in Physician's Training

The Committee had extensive discussion on the changes occuring in the training of physicians in today's environment. Admission officers in some state medical schools have reported that physicians are discouraging young people from entering medical training. They also indicate that there has been a decline in the number of applicants for medical schools in Georgia, such that the pool of applicants is barely enough to fill vacancies available. The increasing restrictions imposed on medical practice by legislation, regulations and the myriad of business and third party payor initiatives to control costs have had a major deteriorating effect on the freedom of physicians to practice medicine.

The Committee felt strongly that the concern for people that leads the vast majority of physicians to choose this profession still exists and that the medical profession must work toward assuring young people that the practice of medicine is still a noble profession in spite of all the negative influences. One of the ways the Committee discussed to enhance the desirability of medical practice was to change the focus of Doctors Day (March 30). This can be done by conducting job fairs and health programs, for example, in local high schools and colleges with the involvement of physicians who can present the positive aspects of entering the practice of medicine.

6. Health Access America

The American Medical Association has developed a 16-point proposal which seeks to ensure that every citizen has access to the benefits of this country's health care system. This proposal is part of a far-reaching campaign — "Health Access America" — that should dominate AMA activities for several years. The campaign will build on the efforts of physicians and medical societies at the national, state, and county levels. Much of the campaign's success will rest on effective grass roots efforts.

At the heart of Health Access America is the problem of the uninsured — 33 million individuals who lack public or private health

MAG members listen to committee reports and resolutions being discussed in this Reference Committee.

insurance coverage. The AMA proposal addresses this problem by recommending required employer provision of insurance and reform of the Medicaid and Medicare programs. In addition, the proposal suggests other measures for extending access and controlling inappropriate health care costs.

Recommendations

1. That MAG and county societies work with the MAG Auxiliary toward changing the focus of Doctors Day (March 30) toward efforts to attract high school and colleges level students into the practice of medicine. *(Referred to Reference Committee D.)*

2. That county medical societies offer the services of an advisory committee to the pre-med advisors in the local community colleges to help encourage students to go into medicine. *(Referred to Reference Committee D.)*

3. That MAG study the AMA Health Access America campaign with the aim of developing specific recommendations to improve access to medical care in Georgia.

HOUSE ACTION

Adopted Recommendation 3 as amended: "That MAG study the AMA Health Access America campaign and other relevant programs with the aim of developing specific recommendations to improve access to medical care in Georgia and specifically report back to the MAG Board of Directors by September, 1990."

CANCER COMMITTEE

LaMar McGinnis, M.D., Chairman

Charge:

Established to provide a coordinating relationship between MAG, the Georgia Department of Human Services, the Division of Cancer Control and the Georgia Division of the American Cancer Society, by making policy recommendations to the Council on Community Services on matters relating to cancer and cancer control and overseeing any MAG activity on programs relating to cancer.

This Committee met early in fiscal year 1989-90 to consider responses to a query to Committee members regarding oncology problems.

1. Third Party Payors

Long standing and increasingly burdensome problems are associated with third party payment (nonpayment) relating to clinical trials, "experimental" treatment, screening procedures and insurability for cancer patients in general. The Committee and MAG have consistently supported any efforts to enhance research, improve treatment and increase appropriate payment for these services. Your Chairman, other Committee members and other physicians are actively involved in the Governor's Commission on Cancer and the Georgia Chapter of the American Cancer Society in their attempts to address these and other issues associated with the prevention, diagnosis and treatment of cancer in Georgia.

The Committee suggested that the MAG Committee(s) on insurance and/or legislation look into basic availability of insurance to cancer patients in Georgia and insurance obligations to pay for clinical trials, outpatient chemotherapy and screening.

2. Mammography

Committee members expressed concern that there are still many women over the age of 50 who have never had a mammogram — even those women who see a primary care physician on a regular basis.

- Until 1986, breast cancer was the leading cause of death from cancer in women. It is still the most frequent cancer in females and second only to lung cancer as the leading cause of death from cancer.
- Early Stage Breast Cancer has an excellent survival rate (90%).
- Mammography and physical examination are proven methods of detecting early breast cancer.
- Mortality has been reduced in randomized screening trials using mammography and physical examination.

The Georgia Chapter of the American Cancer Society has "Check Lists for the Early Detection of Cancer in Asymptomatic Females and Males," which we would encourage all physicians to use for each of their patients — copies are attached to this report.

Representatives of your Committee joined with a coalition of other interested parties that successfully lobbied the 1990 Georgia General Assembly to secure passage of legislation that requires every insurance company that has insurance for any female to offer either as part of a policy or as an optional endorsement, coverage for mammograms and Pap smears for all covered females.

3. Georgia Cancer Control Program

The Committee received a status report on the implementation of mandatory statewide cancer reporting.

The cancer control program has applied for a NCI grant to develop a statewide cancer control program encompasssing education, detection and treatment. This will occur over a seven year period during which data will be evaluated and developed, and an intervention process identified and instituted. Pilot projects will be directed toward cervical cancer, mammography, and tobacco use.

4. There appears to be no need for this Committee to continue as charged. Issues relating to cancer are similar to those related to other diseases and may be appropriately addressed through other existing committee functions, e.g., Third Party Payors, Public Health, and Medical Practice. For this reason your Chairman recommended that the MAG Executive Committee have agreed that this Committee should be sunsetted at the close of this term.

Recommendations

1. That physicians should encourage their female patients to do monthly breast self-examination.
2. That physicians be encouraged to do clinical breast examinations on all female patients for whom they are doing a periodic examination.
3. That in women 40 years and older, a mammogram should be encouraged every 1 to 2 years until the age of 50, after which it should be performed annually.
4. That in women with a personal history of breast cancer, mammograms should be encouraged annually regardless of age.

HOUSE ACTION

Adopted Recommendations 1, 3, and 4.

Adopted Recommendation 2 as amended: "That Primary Care physicians, and any other specialities as indicated, be encouraged to do clinical breast examinations on all female patients for whom they are doing a periodic examination."

MEDICAL ASPECTS OF SPORTS COMMITTEE

Letha Hunter-Griffin, M.D.

The 1989 *MAG Sports Medicine Newsletter* was distributed to high school coaches through the state. Topics covered in the newsletter were "The Need For Athletic Trainers"; "The Use of Anabolic Steroids In Sports"; "Weight Control In High School Athletics"; "Picking The Right Running Shoes"; "Muscle Pulls"; "Street Drugs — Their Action and Reaction"; "Enjoy Pain Free Cycling"; "Exercise During Pregnancy"; "Winning Is An Attitude"; "Cervical Spine Injury In Athletics"; "The Epileptic Athletic"; "Care and Prevention of Common Tennis Injuries"; "Development of a Weight Training Program For Young Athletics"; "Anticipation and Preventing Neurologic Injuries in Sports"; and "Nasal Bleeding: Evaluation and Management."

The articles were written by members of the Medical Aspects of Sports Committee. Pertinent questions were listed at the end of each article to enable coaches to test their knowledge of the subject.

The Medical Aspects of Sports Committee has an active participation at committee meetings. There were 14 members present at the March 1990 meeting.

A video produced by the American Orthopaedic Society is currently being shown in the state to little league coaches upon request. This is a four hour program. There are four (4) members on the committee who have participated in the training program and are monitoring the showing of the video presentation to coaches. Hopefully, this will provide information on first aid for little league baseball players and

will diminish the severity and frequency of injuries incurred by these players.

The U.S. Sports Academy and the National High School Coaches Association are providing leadership in area of coach certification. The Committee supports these efforts and is willing to assist in any way possible.

The Committee encouraged local school boards to hire certified athletic trainers to work under the supervision of team physicians, and encouraged physicians to participate as team physicians.

The Committee reiterated its willingness to serve as a speakers' bureau on sports medicine issues for any organization within the state.

Recommendations

1. That the Medical Aspects of Sports Committee supports MAG's position opposing legislation allowing therapists to evaluate and treat without physician referral.

(Referred to Reference Committee C.)

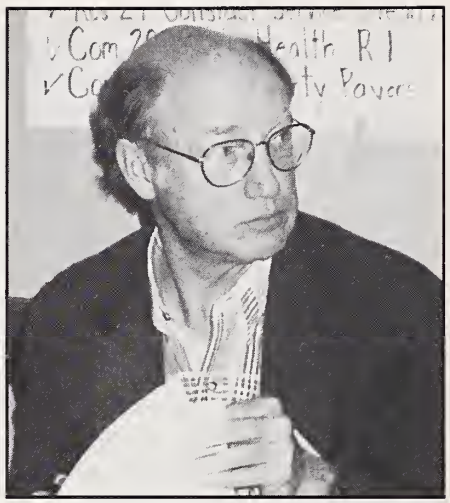
2. That the Medical Association of Georgia favor the pursuit of continued efforts at establishing high school coach certification in medical aspects of sports within the state of Georgia.

3. That the Medical Association of Georgia support the presence of certified athletic trainers within the secondary school system.

4. That the Medical Association of Georgia should continue to encourage physician coverage of high risk sporting events at the high school level.

HOUSE ACTION

Adopted Recommendations 2, 3, and 4 with commendation.



Dr. Frank Carlton, of Savannah, was especially active this past year in working toward solutions of the Medicare problems associated with HealthCare COMPARE and AEtna.

MEDICAL PRACTICE COMMITTEE

Rodney L. Smith, M.D., Chairman

Although the Committee did not officially meet during 1990, the Chairman and staff have had periodic discussions and Committee mailings on several important topics.

The Resource-Based Relative Value Scale: Status of Phase II

Federal legislation passed in December, 1989 — The Omnibus Budget Reconciliation Act of 1989 (OBRA-89), with the phase in of RBRVS, includes the first comprehensive overhaul of the way the Medicare program pays for physician services since the original Medicare law was enacted in 1965.

Beginning in 1992, Medicare payments for physician services will be based on the RBRVS fee schedule, which will replace Medicare's existing "customary, prevailing and reasonable" (CPR) system. Instead of basing payments on historical charges, payments are supposed to now reflect the resources required to perform physician services, including time, effort, overhead and medical liability. The statute mandates that the Department of Health and Human Services (HHS) develop the RBRVS, in consultation with the Physician Payment Review Commission (PPRC). Congress intends that the Harvard RBRVS, as referred by the PPRC, will serve as the basis for the fee schedule. In order to create the fee schedule, the RBRVS rankings are multiplied by a dollar conversion factor. The AMA and national specialty societies have been very much involved in these developments and have provided in depth reports to state societies of their appraisals.

In view of the importance of this fee schedule, we have provided a brief summary of the OBRA provisions related to RBRVS. The new RBRVS payment rates phased in on January 1, 1992 will be as follows: In the case of a service for which the historical payment basis (prevailing charge) is less than 85% of what would be paid under the RBRVS fee schedule, Medicare payments in 1992 will be increased by 15% of the RBRVS fee schedule, in addition to the usual Medicare economic index update. Services whose prevailing charges fall between 85% and 100% of what would be the new payment rates under the RBRVS fee schedule will receive a full increase to the RBRVS fee schedule payments.

From 1993 to January 1, 1996 Medicare payments will be based on a "blend" of 1992 charges and the RBRVS fee schddules, with a greater proportion being based on the RBRVS fee schedule in each subsequent year. On January 1, 1996, the full RBRVS fee schedule rates will be in effect for all services. (For overpriced procedures,

the same process is followed in reverse, i.e. on January 1, 1992, those services that are currently paid at more than 115% of the RBRVS fee schedule will be reduced by 15% of the fee schedule amount, etc.) A model RBRVS fee schedule will not be available for review until the fall of 1990.

Although exact payment levels are not available presently, several simulations have been conducted during the past year to predict the expected effects of RBRVS fee schedules on physicians. You may wish to refer to AMA's May 23, 1989 memorandum and report, *Geographic Simulations Release,* for a summary of the HHS Department's impact study of RBRVS on Medicare payments by geographic area and specialty. Georgia's percent of practices with a loss or gain was listed as follows:

	−30%	*−30% to −10%*	*−10 to 10%*	*10% to 30%*	*>30%*
Georgia	15	32	23	22	8
All States	14	29	26	16	15

Georgia obviously would seem to fare about average among all states in increasing their reimbursements — 30% of practices in Georgia would experience an obvious increase from 10 to over 30% while 31% of the rest of the nation would.

Report C (I-89) of the AMA House of Delegates provides the most recent update on the progress of Phase II of the study in expanding, correcting, and reaffirming the RBRVS. Please refer to this report for further information of these developments.

The Development of Practice Parameters

Also important in 1989, has been the AMA's efforts to develop practice parameters of which the Medcreasingly interested. Interest in parameters as a guide to assist phyical Practice Committee is insicians in clinical decision making has developed in many arenas. The Physician Payment Review Commission has recommended their development by government. The Department of Health and Human Services, the Institute of Medicine, the American Association of Retired Persons, the U.S. Chamber of Commerce, and others are either formulating or proposing parameters for use.

In response, the AMA has involved its constituent societies to work cooperatively to guide their development. Forty-one national medical specialty societies have joined the AMA in declaring to Congress that only physician organizations should develop parameters.

Here in Georgia, HealthCare COMPARE (HCC), as the utilization reviewer for Medicare Part B services, has presented great controversy in their use of "practice parameters" as review policy. In response, MAG has organized a physician specialty review panel to scrutinize HCC's proposed policies prior to implementation. The AMA has participated on an informal basis in these reviews. The Medical Practice Committee feels that quality assurance programs, utilization review systems, and payment policies should be designed to identify and encourage appropriate medical care, and approve such care for payment. There is strong question that the HCC review program is meeting this goal. Accordingly, the Committee recommends that MAG support coordinations of parameter development activities with active involvement of physician organizations, by specialty and geographic area.

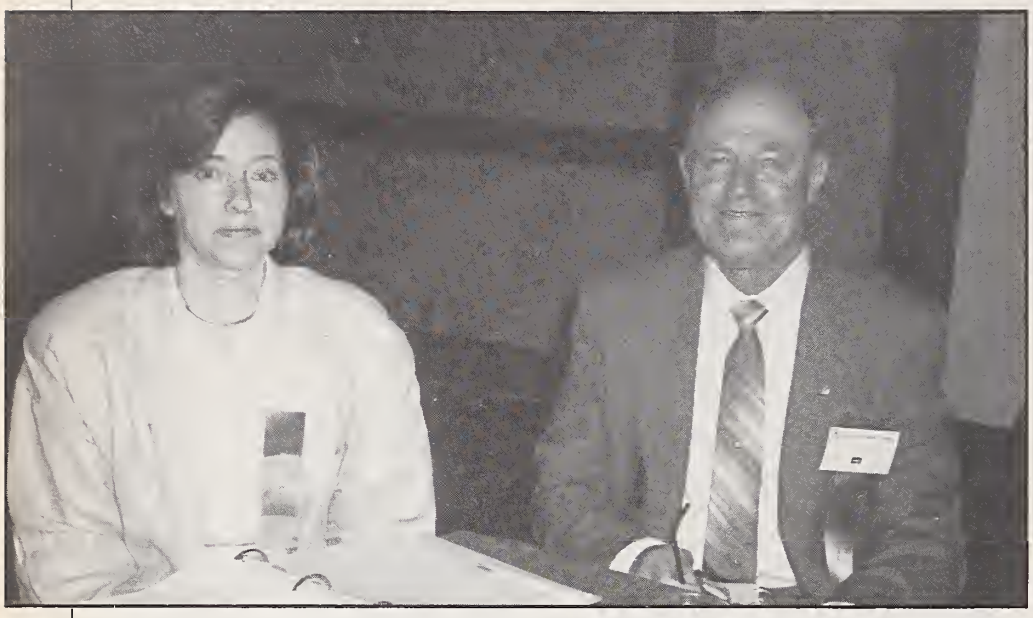
Health Access America

In March, 1990, the AMA released a 16 point proposal to ensure access by every citizen to the benefits of the American health care system. The proposal is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicare program to assure proper health care for all. The plan is based on the foundation of the individual's freedom of choice, combined with a free and independent medical profession — the central aim's of MAG's Medical Practice Committee over the past few years.

As we embark upon the final decade of this century, we feel it essential that medicine present their case — to the government, the public, the insurance industry, and other health care providers — for improving and preserving the U.S. health care system. We feel that the *Health Access America* plan or another comparable statement from our association on these issues is necessary. We feel that it is essential that we articulate the physician's role as the patient's advocate and thus should widely disseminate and discuss this position throughout our state. Please refer to MAG Access to Medical Care Committee for more information on this topic.

Recommendations

1. That the Medical Association of Georgia continue to provide timely status reports to its membership on the development of an RBRVS that will be appropriate for implementation of a Medicare payment schedule.



(L) Cam Taylor, MAG's Director of Medical Practice, was the staff person assigned to Reference Committee B. Dr. Irving Hellenga, of Stephens-Rabun, served on this Reference Committee.

2. That the MAG monitor practice parameter development activities with special attention to the active involvement of physician organizations by specialty and geographic area.

3. That the MAG, as the primary advocate of the patient, study and consider adoption of the AMA Health Access America proposal or other comparable plan during 1990 and carry out all appropriate public relation efforts to publicize this in our state.

HOUSE ACTION

Adopted Recommendations 1 and 2.

Recommendation 3 was considered in conjunction with Recommendation 3 of the Report of the Access to Medical Care Committee. Please see that report for the House Action taken.

PUBLIC HEALTH COMMITTEE

O. Grey Rawls, M.D., Chairman

During 1989, the MAG Public Health Committee continued its charge to identify and analyze problems and trends in the public health environment important to medicine. Biomedical waste, AIDS, Syphilis testing, and listing tobacco as a cause of death, were just a few of the topics and challenges confronting the Committee.

Regulating Biomedical Waste

In June 1989, the Georgia Department of Natural Resources passed, for the first time, specific rules relating to the area of biomedical waste. Their actions, they explained, were due in large part to the increased concerns shown over the past several years by the public about medical waste.

That concern was particularly highlighted when medical related material washed up on beaches during the summers of 1987 and 1988. The adequacy of current medical waste management practices was called into question, and the public health implications became a topic of popular debate.

The Committee, in concert with MAG's General Counsel and the Occupational Health Committee, reviewed the various draft regulations proposed and offered comments on behalf of the Association at public hearings. In addition, the Committee worked in conjunction with the state DNR staff to provide a synopsis of the medical waste rules which were later published in the February issue of the MAG *Newsletter*. These rules have also been available, upon request, by the MAG office.

MAG Clinician's Guide to AIDS and HIV Infection in Georgia

The second printing of the MAG/DHR Clinician's Guide has now been almost fully depleted and consideration is being made for a new updated version.

Many other state medical societies have now also published similar such educational reports, and in some instances, such as with the Florida Medical Association, Inc., have used them for fulfillment of state CME requirements. The Committee will assess the possible usefulness of a revised Guide for Georgia physicians and plan accordingly.

Syphilis Testing and Prevention

Also during 1989, the Committee was asked to review proposed rules of the Georgia Department of Human Resources concerning "Serologic Tests for Syphilis for Pregnant Women." These new rules would have required all pregnant women to be tested for syphilis both

during the early phases of pregnancy and again during the third trimester of gestation. Through consultation with the Georgia OB-GYN society and other MAG physicians, the Committee was influential with the Department in persuading them against this blanket approach to Syphilis prevention and urged them to focus their efforts instead on the populations at greatest risk.

The Committee also recommended the appointment of a MAG Obstetrician/Gynecologist to a special DHR study committee on the growing Syphilis outbreak throughout Georgia.

Pinpointing Tobacco use as a Contributing Cause of Death

In response to the 1989 MAG House Resolution 13, which encouraged physicians "to list tobacco on Georgia death certificates as a contributing factor to the cause of death," the Committee discussed several strategies. It was recommended that several repeated announcements encouraging such reporting be made to the MAG membership through the MAG *Newsletter* or *Journal*, as appropriate.

Recommendations

1. That the Public Health Committee continue its scrutiny of new federal and/or state laws and regulations concerning biomedical waste to insure that such protective measures are commensurate with research findings and that they are clearly communicated to physicians and their staff.

2. That the Public Health Committee assess the possible usefulness and/or appropriateness of an updated and newly printed version of a Clinicians Guide to AIDS and HIV Infection in Georgia. *(Referred to Reference Committee F.)*

HOUSE ACTION

Adopted Recommendation 1.

THIRD PARTY PAYORS COMMITTEE

C. Peter Lampros, M.D., Chairman

Refer to the Report of Reference Committee A for the full report of the Third Party Payors Committee.

Recommendations

1. That MAG continue its rigorous monitoring of the Medicare Part B operation in Georgia and stand firm in its support for laws and regulations which enhance the provision of medical care and the patient-physician relationship.

2. That MAG continue to communicate and inform physicians in a timely manner of the ongoing federal changes in the Medicare reimbursement system. *(Referred to Reference Committee A.)*

3. That MAG carefully monitor the implementation of HB 1813, the Utilization Review Regulation, in Georgia and inform physicians of their rights in this very important piece of legislation.

4. That MAG formally express its sincere gratitude to Dr. Joseph P. Bailey, Jr., for his sagacious and exceptional leadership of our efforts in meeting the Medicare dilemma in Georgia. *(Referred to Reference Committee A.)*

5. That MAG formally convey its appreciation to Thomas Anderson, Jr., M.D.; Anthony Castrini, M.D.; Frank Carlton, M.D.; Albert Carr, M.D.; Robert Copeland, M.D.; Charles Harrison, M.D.; Paul Jurgensen, M.D.; Joe Nettles, M.D.; James Van Buren, M.D.; and Donald Wright, M.D. for their energetic and tenacious activities on behalf of the medical profession in meeting the current Medicare dilemma. *(Referred to Reference Committee A.)*

HOUSE ACTION

Adopted Recommendation 1.

Adopted Recommendation 3 as amended: "That MAG, through its Legislative Council, do all in its power to seek adequate funding for H.B. 1813, the Utilization Review Regulation Act."

RESOLUTION 4

Georgia Medical Care Foundation Board

James Q. Whitaker, M.D.

Whereas, in the past, some members of the Board of Directors of the MAG have also served as members of the Board of Directors of the Georgia Medical Care Foundation; and

Whereas, there is concern that serving on both boards creates a conflict of interest; now, be it therefore

RESOLVED, that no member of the Board of Directors of the Medical Association of Georgia be allowed to serve on the governing board of the Georgia Medical Care Foundation.

HOUSE ACTION

Did not adopt.

RESOLUTION 5

Cost of Home Health Care

Bibb County Medical Society

Whereas, Medicare regulations require physicians to authorize various home health care services or equipment; and

Whereas, the suppliers of these services generally do not apprise the authorizing physician of the cost of this equipment or services; and

Whereas, some of this equipment or services may be extremely expensive, allowing said suppliers to profit inappropriately from the Medicare program; now, therefore be it

RESOLVED, that HCFA require that any order presented to a physician by a supplier of medical equipment and medical supplies, especially any home health care order, include the supplier's charges for the equipment and supplies to be provided to the patient.

HOUSE ACTION

Adopted as amended: "RESOLVED, that MAG request HCFA to require that any order presented to a physician by a supplier of medical equipment and medical supplies, especially any home health care order, include the supplier's charges for the equipment and supplies to be provided to the patients."

RESOLUTION 8

AMA Investigation of Medicare

Medical Association of Atlanta

Whereas, it is becoming increasingly difficult for both physician and hospital providers to manage Medicare patients and remain fiscally solvent; and

Whereas, Medicare's mandates, over the last two or three years, have gradually forced the profession of medicine into the position of a public utility against its will and without the protection of other public utilities; and

Whereas, it is not reasonable for physicians individually to learn what are actually Medicare laws; what are formal rules and regulations, and what are simply memoranda-to-carriers (the latter may differ carrier to carrier); now, therefore be it

RESOLVED, that the Medical Association of Georgia encourage the AMA to create a special subcommittee of the Council on Medical Service as a Medicare watchdog committee for the purpose of ascertaining, in detail, the above uncertainties and reporting to the AMA House of Delegates, on an ongoing basis, its findings.

HOUSE ACTION

Adopted.

RESOLUTION 9

Legal Action Against Medicare

Medical Association of Atlanta

Whereas, Medicare is steadily converting the medical profession into a public utility by:

1. freezing physician fees;
2. setting physician fees;
3. violating the freedom to contract by mandating that physicians file insurance forms for Medicare patients as of September 1, 1990;
4. violating the freedom to contract by refusing to allow Medicare beneficiaries to contract with physicians outside the limitations of Medicare;
5. invoking monetary penalties rather than simply eliminating physicians they consider undesirable from the program;
6. using public funds to persuade patients to force their physician to accept assignment; and
7. legislating the establishment of the NATIONAL PRACTITIONER DATA BANK and its projected contents (which may also serve as a trial balloon on the pathway to federal licensure as well as making acceptance of Medicare and Medicaid patients a mandatory condition of licensure); now, therefore be it

RESOLVED, that the Medical Association of Georgia encourage the AMA to investigate (in light of AMA Report Z of the Board of Trustees from the 1989 Interim meeting) legal and legislative action to stop this surreptitious conversion of the medical profession into a public utility.

HOUSE ACTION

Adopted.

RESOLUTION 14

Means Test for Proposed Medicare Recipients

Bibb County Medical Society

Whereas, health care costs are rising faster than the Consumer Price Index; and

Whereas, a significant majority of Medicare recipients, including some who are millionaires, are not medically indigent; and

Whereas, Congress has not addressed a means test for Medicare recipients as a method of reducing health care costs; now, therefore be it

RESOLVED, that the American Medical Association sponsor legislation requiring a means test for Medicare recipients; and be it further

RESOLVED, that the Georgia Delegation submit such a resolution to the AMA House of Delegates at its 1990 annual meeting.

HOUSE ACTION

Adopted the first RESOLVED as amended: "RESOLVED, that the American Medical Association sponsor legislation requiring a means test for Medicare recipients as part of an overall comprehensive revision of the Medicare law."

Adopted the second RESOLVED.

RESOLUTION 20

Established Medicare Payment Profiles

Bibb County Medical Society

Whereas, long established physicians' payment "profiles" frequently lead Medicare to reimburse older physicians at lower levels than physicians with newly established payment profiles; and

Whereas, medical practitioners should be reimbursed at levels which recognize their clinical experience, or at least at the same levels as younger physicians with new Medicare profiles; now, therefore be it

RESOLVED, that the Medical Association of Georgia monitor the implementation of the new RBRVS form of Medicare reimbursement to ensure that inequities currently existing in reimbursement between younger and older physicians are eliminated.

HOUSE ACTION

Adopted as amended: "RESOLVED, that MAG immediately voice to the Georgia Congressional Delegation its opposition to the provisions in the fiscal year 1991 Budget, before Congress at this time, which would result in age discrimination against young physicians."

RESOLUTION 21

Consideration of Service Site in Reimbursement

Bibb County Medical Society

Whereas, physicians' patterns of patient billing reflect not only the procedure or service performed but the site of its performance (e.g., office visit vs. nursing home visit); and

Whereas, such differences of service site logically lead to differences in physicians' charges; and

Whereas, Medicare reimburses physicians for a given "procedure code" regardless of the site of its performance; now, therefore be it

RESOLVED, that the Medical Association of Georgia monitor the upcoming implementation of the Resource-Based Relative Value System, to ensure that consideration is given to location and setting of a physician's service in the determination of Medicare reimbursement for that service.

HOUSE ACTION

Adopted.

RESOLUTION 22

Billing by Physicians for Coverage by Colleagues

Bibb County Medical Society

Whereas, the MAG Board of Directors in October 1980 affirmed its support of physicians billing HCFA

for medical services rendered by colleagues "covering" for them; and

Whereas, the AMA House of Delegates affirmed similar support of billing by a patient's personal physician rather than the colleague who provides "coverage"; and

Whereas, a recent MAG survey of the fifty state medical association disclosed that in forty-three states, billing is routinely made by the patient's personal physician; now, therefore be it

RESOLVED, that the MAG House of Delegates voice its support of AMA action to "pursue all appropriate legislative means to amend appropriate Sections of the Social Security Act and/or HCFA regulations to make it possible for physicians in solo practice and those in the same or different groups to 'cover' Medicare patients for each other, and make it possible for personal physicians of Medicare patients to bill and receive reimbursement for professional services rendered by their colleagues who 'cover' for them"; and be it further

RESOLVED, that the Georgia Delegation bring forth to the MAG House a report on the AMA's success in amending the aforesaid Sections.

HOUSE ACTION

Adopted the first RESOLVED as amended: "RESOLVED, that MAG members contact Georgia's U.S. Congressional Representatives and Senators as well as other state medical societies for support of H.R. 4475."

Adopted the second RESOLVED as amended: "RESOLVED, that the Georgia AMA Delegation bring forth to the MAG House a report in 1991 on the AMA's success in amending the Sections of the Social Security Act, HCFA regulations, and related issues."

RESOLUTION 23

Abuses in Home Health Care

Laurens County Medical Society

Whereas, the Georgia Medical Care Foundation was authorized last year by HCFA to begin quality reviews of home health care agencies in response to concerns voiced by patients and physicians; and

Whereas, various home health care agencies in Georgia may be engaging in questionable practices or unprofessional, techniques that adversely affect medical care and the costs thereof; now, therefore be it

RESOLVED, that MAG should work through the Georgia Medical Care Foundation to encourage HCFA to conduct a conscientious and deliberate evaluation of commercial firms providing home health care, with special emphasis on the quality of care provided and the professional practices of such firms; and be it further

RESOLVED, that the MAG and the Foundation cooperate in suggesting appropriate corrective action to be taken by HCFA against those firms found to be engaging in questionable or unprofessional practices.

HOUSE ACTION

Adopted.

RESOLUTION 26

Medicaid Precertification

James Q. Whitaker, M.D.

Whereas, Georgia's new Medicaid precertification regulations took effect on March 1, 1990, imposing significant new requirements that detrimentally affect patients and physicians; and

Whereas, this precertification program was developed well before the MAG Board of Directors was informed of it (at the Board meeting in Albany, January 13); and

Whereas, members of the MAG Board who also serve on the Georgia Medical Care Foundation Board of Directors therefore failed to apprise the MAG Leadership sufficiently of this onerous Medicaid requirement; now, therefore be it

RESOLVED, that the MAG Board of Directors call upon the Georgia Medical Care Foundation for an explanation of how the Medicaid precertification program was developed; and be it further

RESOLVED, that MAG initiate an investigation as to the effectiveness of precertification as a medical care cost containment measure.

HOUSE ACTION

Referred to the MAG Board of Directors.

RESOLUTION 28

Medicaid Precertification

Glynn County Medical Society

Whereas, the Georgia Department of Medical Assistance (Medicaid) has recently instituted a program requiring precertification for elective hospital admission and outpatient surgical procedures; and

Whereas, the precertification program is based on the supposition that money can be saved by such a program although such review has not been shown to be effective, and has in fact been abandoned by several major insurers; and

Whereas, the administration of this program will not only cost Georgia taxpayers money, but will also result in little if any savings, while reducing the amount of funds available to pay for needed care; and

Whereas, such precertification vastly increases the administrative burden on physicians and hospitals, thereby increasing costs of providing care; and

Whereas, adequate mechanisms for review of appropriateness and quality of care were present prior to initiation of this program; and

Whereas, this program will significantly increase the difficulties encountered by Medicaid beneficiaries in obtaining needed care; now, therefore be it

RESOLVED, that the Medical Association of Georgia, in the interest of public good, make known to the people of Georgia the full costs of this program in both direct monetary expenditure, increased "red tape," and decreased access to care; and be it further

RESOLVED, that MAG work to have this costly, wasteful and onerous program ended.

HOUSE ACTION

Referred to the MAG Board of Directors.

RESOLUTION 31

Drug Treatment Programs for Youth and Women

Alfred L. Davis, Jr., M.D.

Whereas, throughout the State of Georgia there are only 45 beds for indigent youth drug treatment (15 beds in each of 3 facilities); and

Whereas, the need for beds far exceeds the current availability; and

Whereas, this indicates a pressing need for adolescent substance abuse detoxification and outpatient counseling programs in this state; and

Whereas, inpatient treatment should be available to those crack abusers who voluntarily seek treatment, with priority given to pregnant mothers; and

Whereas, a successful pilot program of case management and follow-up of high risk patients, including substance-abusing pregnant mothers, has been developed in the Eighth Public Health District; now, therefore be it

RESOLVED, that the Medical Association of Georgia collaborate with the appropriate state government agencies to see that the Eighth Public Health District's program of high-risk adolescent substance abuse case management be extended throughout the state.

HOUSE ACTION

Adopted with commendation.

RESOLUTION 37

MAG Support of Hospital Medical Staff

Hall County Medical Society

Whereas, the physicians serving Lakeside Community Hospital in Cumming, Georgia have had long-standing, unresolved conflicts with the hospital administration regarding quality of care issues; and

Whereas, in an effort to resolve these unacceptable prevailing conditions, certain physicians sought and have received community and political support; and

Whereas, said hospital unilaterally revoked the hospital medical staff privileges of virtually the entire staff; and

Whereas, said hospital has brought suit against certain physicians alleging violation of slander, antitrust and other laws creating significant legal fees incurred by those physicians; now, therefore be it

RESOLVED, that the plight of these physicians be brought to the attention of MAG's Executive Committee for study and appropriate assistance; and be it further

RESOLVED, that the issue of the unilateral termination of staff privileges be brought before the AMA and that the AMA's assistance be sought in helping these physicians; and be it further

RESOLVED, that the Georgia Delegation to the AMA introduce an appropriate resolution to the 1990 AMA House of Delegates seeking the AMA's assistance for these physicians.

HOUSE ACTION

Adopted the following substitute resolution in lieu of this resolution:

"RESOLVED, that MAG express its opposition to the unilateral dissolution of a hospital medical staff or the unilateral amending of medical staff bylaws; and be it further

"RESOLVED, that the MAG Delegation submit an appropriate resolution to the 1990 Annual meeting of the AMA seeking all possible help and assistance of the AMA, including financial and legal, for AMA physician members of any medical staff where the medical staff bylaws have been unilaterally amended by the hospital administration; and be it further

"RESOLVED, that the Board of Directors or its Executive Committee provide appropriate assistance, including consideration of the formation of a legal defense fund, for MAG physicians who are members of a medical staff where the medical staff bylaws were unilaterally amended by the hospital administration."

RESOLUTION 39

GMCF to Administer UR for Medicare Part B in Georgia

Frank E. Carlton, M.D.

Whereas, HCFA's original determination to employ a private utilization review firm apparently did not consider the potential conflict of interest any such relationship would create; and

Whereas, the entrepreneurial nature of that relationship will, under most circumstances, cause more harm to be done to the "good" practice of medicine than corrective measures be taken against "bad" medicine; and

Whereas, HealthCare Compare has demonstrated repeatedly,

— its apparent inability to explore the potential for compromise in negotiation,

— its apparent determination to pursue an adversarial and demoralizing program, and

— its determination to reduce Medicare costs as a primary objective, subordinating other relevant concerns; and

Whereas, HealthCare Compare's utilization by HCFA is one of the major factors in undermining the private practice of medicine in Georgia, which may have national implications; and

Whereas, under current Medicare Law, there is no legal basis upon which to address various inequities through the courts; now, therefore be it

RESOLVED, that the Medical Association of Georgia beseech the Congressional representatives of Georgia in both the House and the Senate to enact new legislation requiring HCFA to utilize the services of the Georgia Medical Care Foundation to administer Medicare Part B.

HOUSE ACTION

Referred to the MAG Board of Directors for legal review and study.

RESOLUTION 47

Medicaid Formulary

Joseph P. Bailey, Jr., M.D.

Whereas, the Department of Medical Assistance has imposed a limited formulary on the Medicaid patients of the State of Georgia; and

Whereas, this restrictive formulary limits the ability of the physician to choose the best medications he or she feels is most appropriate to treat this already disadvantaged group; now, therefore be it

RESOLVED, that MAG exercise all means available to insure immediate restoration of an open formulary in the Medicaid program.

HOUSE ACTION

Adopted.

RESOLUTION 58

Medical Staff Support

Hospital Medical Staff Section

Whereas, there have been instances where the ownership and/or governing authority of a hospital have unilaterally dissolved or amended the existing medical staff; and

Whereas, such dissolution may be in direct conflict with the existing medical staff bylaws of that facility; and

Whereas, JCAHO regulations prohibit the unilateral changing of bylaws by either the medical staff or the hospital governing authority; and

Whereas, it is not in the best interest of quality patient care to unilaterally dissolve a medical staff; and

Whereas, the financial assets of a hospital usually are extensive, thus their ability to utilize the judicial system is much greater than that of the medical staff; and

Whereas, the medical staff where a unilateral dissolution has occurred is in need of the assistance of their fellow physicians; and

Whereas, it has been alleged that the Lakeside Community Hospital administration issued an amended set of medical staff bylaws that were not approved by the existing medical staff; now, therefore, be it

RESOLVED, that MAG express its opposition to the unilateral dissolution of a hospital medical staff or the unilateral amending of medical staff bylaws; and be it further

RESOLVED, that the MAG Delegation submit an appropriate resolution to the 1990 Annual meeting of the AMA seeking all possible help and assistance of the AMA, including financial and legal, for the physician members of any medical staff where the medical staff bylaws have been unilaterally amended by the hospital administration; and be it further

RESOLVED, that MAG recognize the struggle and efforts of the physicians who formerly were members of the Lakeside Community Hospital medical staff and seek to give them appropriate assistance as approved by the Executive Committee or Board of Directors.

HOUSE ACTION

This Resolution was considered in conjunction with Resolution 37. Please see Resolution 37 for House Action taken.

Report of Reference Committee

The following physicians served on Reference Committee C: James L. O'Guinn, Chairman, Richmond; Asa Yancy, Vice-Chairman, Atlanta; Albert G. Yancy, Richmond; John S. Antalis, Whitfield-Murray; Roy W. Vandiver, DeKalb; Catherine S. Andrews, Cobb; Billy D. Burke, Floyd-Polk-Chatooga; and Joe C. Stubbs, South Georgia. MAG Staff: Cynthia Haney, Assistant Legal Counsel.

OFFICE OF THE PRESIDENT

Joe L. Nettles, M.D.

(Refer to the Report of Reference Committee B for the complete text of the President's report.)

Recommendations

1. MAG through the combined efforts of the Ad Hoc Committee on Citizens Advocacy, and the Public Relations Committee launch a positive program to insure that the health care needs of all the citizens of Georgia are met, utilizing the successful efforts of South Carolina or Kentucky as a model. *(Referred to Reference Committee B.)*
2. MAG continue an all out effort to insure that good obstetrical care is available throughout Georgia.

HOUSE ACTION

Adopted with commendation.

REPORT OF THE IMMEDIATE PAST PRESIDENT

Joseph P. Bailey, Jr., M.D.

The Medicare Program in Georgia has been the major, but not the only focus of this office during the past year. The advent of AEtna as the insurance carrier in January 1989 heralded the onset of great difficulty for patients and physicians in our State, difficulties which have continued to the time of this report. Not only was a new carrier present, but a pilot experimental project was initiated by HCFA for utilization review, hiring a for-profit organization out of Downer's Grove, Illinois, Health-Care COMPARE which never before had done physician reviews, but only hospital utilization review. These new programs in Georgia brought with them the intervention of the Medical Association of Georgia to evaluate the catastrophic changes that subsequently developed. Some of these changes have

included tremendous backlogs of unprocessed claims, an impossible appeals process, down-grading of claims for comprehensive services, the disallowing of claims for consultative care stating this was unallowable concurrent care, failure to adequately handle electronic billing, inaccurate payment for services when payment was rendered, and poor communication responses, to mention some of the problems. In addition, there were the problems of disallowing payment for monthly visits to nursing homes as required by Georgia Law, and the requirement for cross-coverage physicians to bill independently of the primary physician.

Your organization has worked diligently to alter the state of affairs that now exists. There have been multiple and continuing meetings with AEtna, HCC and HCFA at least monthly and often more frequently. We have conducted surveys. Meetings with the Georgia Congressional delegation were held and a Congressional hearing by Representative Henry Waxman's subcommittee was convened in Atlanta. Congressman Roy Rowland has been a staunch supporter of patients and physicians in our State, as have the other Georgia Congressional delegation members. Attached are three documents representing, in part, efforts to alter the current situation.

This catastrophe remains an ongoing source of contention and our directed effort has been to cancel the contract for HCC utilization review activities for Medicare in Georgia. Your organization and its staff, particularly Mrs. Camilla Taylor, Mrs. Priscilla Daves, Mrs. Donna Glass and Mr. Paul Shanor have worked tirelessly to accomplish the needs of the patients and our physicians. This will continue as an ongoing battle requiring honesty, skill, and tenacity to win. We need to continue our efforts in this war and concentrate on each battle but never be dissuaded by temporary set backs. Truly, the issue of how we are to care for our aging population is at hand. Without our intervention, it will be treated as an economic issue and not one directed at true medical need. Is the beginning of a rope holding you on a mountainside more important than its end? The analogy to life and health — birth to aging — may be the same.

James L. O'Quinn, M.D., of Richmond County, Chairman of Reference Committee C.

Another major source of concern has been the alterations in the Medicaid Program under the Department of Medical Assistance. This year has been noted by the imposition of a restricted formulary, particularly with regards to NSAIDS. Also, there has been imposed a requirement of pre-admission certification for Medicaid patients. In a society where emphasis on helping the millions of indigent or near indigent citizens has intensified, the development of governmental constraints on their medical care is paradoxical. Governmental intervention has in fact created a two-tiered medical system where Medicaid patients may not necessarily receive the medications of the physician's choice. This places a state governmental agency in the position of practicing medicine or certainly controlling your medical judgment and decisions.

The Medicare and Medicaid issues are examples of the tremendous amount of time, attention and expertise required from MAG staff to address the increasingly complex problems faced by Georgia's physicians. In order to meet the demands that modern medical practice places upon physicians and those that represent them, I have

two suggestions to pass along from the vantage point of the Immediate Past Presidency.

First, MAG needs to consider an increase in staffing so that adequate personnel are available to focus on key problem areas. As we presently stand, the scope of MAG's concern far exceeds the capacity of a staff that already often labors evenings and weekends to handle the ever increasing workload. We need to re-evaluate the demands on us and staffing requirements. Second, in order to attract new people and retain the excellent staffers presently employed by the Association, MAG needs to consider increasing the compensation and form of benefits of key personnel. They have proven their loyalty to us and we need to ensure their continued valuable services.

I personally wish to thank the Executive Committee, the Board of Directors, the House of Delegates and the membership of the Medical Association of Georgia for the opportunities provided me to work for the good of medicine in our State and Nation. It has been, and is, the pinnacle of my life. As I conclude this year, I also wish to thank the staff of MAG for their tremendous support and loyalty under the leadership of Mr. Paul Shanor. These people are a vital and absolute ingredient in our success.

Finally, I wish to thank my wife, Pagie, for her untiring support of our organization and my efforts in its behest.

Non Teum Illigitimos Carborundum.

Recommendations

1. That legislation be pursued which would protect the ability of physicians to control medical judgment and decisions about their patients. This recommendation extends to both the issues of Medicare and Medicaid. It should also be implicit that the issues deemed unalterable by legislative change be evaluated as to other avenues of definitive approach. These issues are coupled with the absolute need by adequate compensation for the practice of medicine in Georgia.

2. That MAG evaluate the need for expanded staffing and appropriate monetary, other benefits and recognition of our staff now present. *(Referred to Reference Committee F.)*

HOUSE ACTION

Adopted Recommendation 1 with commendation.

Attachment 1

PRINCIPAL POINTS

Statement of the Medical Association of Georgia

To the Subcommittee on Health and the Environment Committee on Energy and Commerce

RE: Health Care for Georgia's Elderly: Fair Payment for Medicare Services

Presented by Joseph P. Bailey, Jr., M.D. March 5, 1990

The time for experimentation on Georgia's Medicare patients and physicians is over. It is a proven disaster. A stable reimbursement review program respected by the Georgia medical community making use of open and clearly stated reimbursement policies consonant with advanced medical technology is now necessary.

Physicians in Georgia have a long history of commitment to the elderly patients of our state. It is our continued concern and commitment to our patients that brings us before you with our plea to help restore to our health care system a sense of trust, of integrity, of fairness and of decency. We come to you with serious suggestions of ways to aid in this restoration.

The Medical Association of Georgia suggests that efforts be taken immediately to terminate the formal contract arrangements with the HealthCare COMPARE Corporation of Chicago and a new utilization review program be engaged.

There is a provision in the contract between AEtna and HealthCare COMPARE that allows AEtna, "at its sole discretion," to terminate the contract at any time with 90 days written notice. This provision should be utilized immediately.

Such an arrangement could be suitably made with the present Medicare Part B carrier or with a comparable Medicare Part A review agency — such as the Georgia Medical Care Foundation. This alternative arrangement would be consistent with current Federal interest in possibly aligning Medicare Program components.

Further, a focused utilization review approach by the newly appointed, adequately experienced, and well regarded review unit should be better targeted to the identification and elimination of reimbursement abuse when present.

The Medical Association of Georgia supports:

- Development of a new, simple-language, Utilization Review instruction set that enables physicians to know and track changes in medical review policies for approvable services to the elderly.

Serving on Reference Committee C were (L to R): Asa G. Yancey, M.D., Vice Chairman, Richmond; John S. Antalis, M.D., Whitfield-Murray; and Billy D. Burke, M.D., Floyd-Polk-Chatooga.

- Engagement of an outside consultant management team to assist in streamlining the administrative operation of the claims processing in light of pending legislative reform; more specifically the use of the RBRVS for reimbursement.
- Launching of a public relations effort between the Medicare carrier and Medicare recipients and the physician community to reestablish mutual physician-patient trust concerning reimbursement decisions.
- Completion of claims adjustments to adequately compensate for financial loss and provision of adequate explanation to the patient in case of misapplication of policies.
- Amendment of the Medicare law offered by Senator Howell Heflin of Alabama that would allow the attending physician to bill for Medicare even when coverage is provided by a covering physician. As Doctor — and Congressman — Rowland knows, such billing procedure provides that payment flows with responsibility, and provides for less patient confusion. Over forty-three states currently bill Medicare in this manner, and Senator Heflin's amendment would simply recognize current practice. (See *Congressional Record,* Vol. 136, No. 7, Feb. 1, 1990.)
- Introduction of language in section 1869 of the Social Security Act to provide that persons providing services to Medicare patients may have a legal remedy in the patient's or their own name when the carrier fails to abide by the law or HCFA's regulations, rules, or policies.
- Regulation of utilization review agencies. There are at present no standards for either the companies or their reviewers. The insurance companies are regulated, the physicians are regulated, but there are no state or federal standards for UR companies.
- When a large number of denials occurs, and is caused by a single policy and affects several physicians, the physicians should be able to appeal in a group and be represented by their state medical society or association.
- Extend physician time frames for "participation decisions" by the same amount of time granted to the AEtna carrier.

The Medical Association of Georgia believes that these steps are vital to bring the Medicare Part B program under control again.

The Medical Association of Georgia believes that the current program for Medicare utilization review in Georgia is untenable and has lost any degree of credibility that might have existed.

The Medical Association of Georgia is very concerned about the state of confusion and disarray of the program's administration. The long standing difficulties can no longer be attributed purely to a conversion event.

(Editor's NOTE: for the full text of MAG's statement to the Subcommittee, call the Legal Counsel at MAG Headquarters, (404) 876-7535).

MAG COUNCIL ON LEGISLATION

James A. Kaufmann, M.D.

THE CLOSE of the 1990 Session of the Georgia General Assembly saw passage of approximately one-seventh of the 4673 pieces of legislation considered by the Senators and Representatives of Georgia during their 1989-1990 term. Over 700 bills were passed, not including parliamentary and constitutent resolutions. MAG tracked more than three hundred bills — more than any other organization of which we are aware. And it is with great pleasure that we say that the patients and physicians won on virtually all major medically related issues that came before the General Assembly this year.

You should also know that because of the effective work by individual physicians and our Legislative Team prior to the convening of the 1990 General Assembly, several significant issues were successfully blocked. Sometimes our victories are marked by the *absence* of a piece of legislation that another group may have planned. The "triple script" bill and a proposed major rewrite of the chiropractic scope of practice were never introduced at all, and several versions of mandatory assignment were defeated before they were able to gain any momentum. You owe yourselves a pat on the back because your contracts with Legislators prior to the Session paid sizeable dividends.

A run-down of the major issues follows:

HB 1813 — Utilization Review Regulation Bill

The single most important health care bill to pass the General Assembly this Session sailed through the House with only five dissenting votes and passed the Senate unanimously! The bill was dead for all intents and purposes until the MAG Legislative Team not only brought it back to life — which was miraculous enough — then Rep. Tommy Chambless, author of HB 1813, and Richard Greene, head of the Legislative Team and MAG's General Counsel, got funds in the 1990 State budget to implement the program.

HB 1813 will regulate utilization review companies in Georgia, setting standards for the reviewers that will put all on a level playing field. The bill is a common-sense approach to holding down medical costs by requiring U.R. companies to be certified to meet minimal standards. Virtually all of the insurance companies (except Blue Cross-Blue Shield of Georgia) fought us on this one. An important aspect of the legislation is a provision that will allow the attending physician to speak to a reviewing *physician* when services are denied. This bill will be a major step in getting reviews that are accurate and fair to the patient. The Governor will have signed HB 1813 as of April 10, 1990.

HB 1698 — Physical Therapists Bill

The MAG Legislative Team worked hard to hold HB 1698 in the House Rules Committee, ensuring that this disastrous bill did not pass this Session. Former Representative Joe T. Wood, now an essential part of MAG's Legislative Team, played a vital role in helping to defeat HB 1698. HB 1698 would have handed physical therapists the ability to practice without ever consulting a physician about the patient. Your efforts in telling your legislators that pain can signal many problems, some life threatening, which physical therapists are not qualified to diagnose, was a major factor in the outcome.

HB 1609 — Group Health Insurance Policies — Nonmandated Benefits

HB 1609 is designed to allow insurance companies and employers of 25 or fewer persons to enter into insurance contracts that provide only those benefits, coverages, and reimbursement for services to which the parties mutually agree. The idea is to permit the employers to purchase customized insurance coverages without having to buy every mandated coverage as required under current law.

MAG supports the concept of permitting the sale of insurance that does not have all of the mandated coverages such as chiropractic, etc. However, HB 1609 became increasingly flawed as it progressed through the legislative process including mandated coverage for chiropractors, psychologists, and optometrists. Passage of some of the offered versions would have been very detrimental to patients, hospitals and physicians. MAG's major objection was that there were no protections for consumers which would have established a basic, minimal policy. HB 1609 could have meant that employers could force employees to have coverage that allowed only one physician visit per year, or a $200 maximum for hospitalization.

The idea of selling both "Volkswagon" and "Cadillac" health insurance policies is fundamentally sound. MAG intends to contribute significantly this summer and fall

in working out an agreeable version. The version that MAG considered more deleterious to patients and physicians was very vigorously pursued by the insurance industry, the Georgia Business Council and the Georgia Chapter of the National Federation of Independent Businesses. It was MAG's effective opposition that finally defeated HB 1609 over these considerable adversaries.

SB 553 — Healthy Baby Bill

SB 553 is in the Governor's office awaiting his signature and eventual appointments to a Governor's Blue Ribbon Commission to study the OB Crisis in Georgia. While it is always disappointing to see a good bill delayed by a small group, the women and children of Georgia deserve a solution to this crisis. We need an arbitration jury bill to pass in 1991. This Governor's Commission follows the pattern of high level review that led to the tort reforms of 1976 and 1987. The Commission will have 19 members, three of whom will be physicians recommended by MAG. There will also be three female citizens, two nurses, a Georgia Hospital Association representative, an insurance indemnity person, and three attorneys.

HB 842 — HIV Testing

HB 842 was used as a legislative vehicle to attach language that authorizes a physician to order an HIV test on a patient even without the patient's consent if a health care worker has been "exposed" to the blood or other body fluid of a patient. Prior to running the test, the patient must be notified, but the patient's permission is not necessary. The physician ordering the test must get another physician to agree to the testing and such testing must be in compliance with the CDC infectious disease guidelines or the infectious disease guidelines of the local hospital. Counseling and the test results must be provided to the patient. If the test results are negative, then the results will not become a part of the patient's record without the patient's consent.

HB 842 originally merely covered a re-writing of the statute concerning the disclosure of "AIDS confidential information" in certain judicial proceedings involving persons who are alleged to be mentally ill, mentally retarded, or alcoholic or drug dependent. Both sections were passed by the General Assembly.

The original amendment offered by Rep. Tommy Chambless at the request of numerous physicians from Albany and all across Georgia authorized non-consent testing in pre-surgery situations. The Department of Human Resources and some AIDS rights groups also opposed the change. The version that finally passed, which permits testing when there has been an exposure to a health care worker, is in keeping with the AMA's position. AMA is currently evaluating whether to suggest HIV testing in certain pre-surgery situations as well.

Everyone recognizes that physicians, nurses and other members of health care teams are constantly at risk for needle sticks, scalpel cuts, blood splatters and other accidents with the pontential for spreading the HIV virus. MAG feels strongly that physicians and staff have the right to know if they have been exposed to the body fluids of HIV-positive patients.

HB 842 will become effective upon signature of the Governor.

HB 1505 — Cosmetic Tattooing

After a bitter fight, MAG was successful in getting this important piece of consumer legislation passed that will protect patients from tattoos and indelible markings within an inch of the eye socket. The Georgia Society of Dermatologists, the Georgia Society of Ophthalmology, and the Georgia Society of Plastic Surgeons, in concert with MAG, supported this bill in an attempt to eliminate the dangerous practice of tattooing "permanent eyeliner." Thanks go to the various specialty societies whose spirit of cooperation and hard work helped pass HB 1505.

There were numerous other bills that MAG was actively involved in either supporting, modifying or defeating. One of the most hotly contested bills addressed the establishment of a statewide medical examiners system and a general upgrading of death investigation in Georgia. MAG won on four of the five amendments we sought to HB 1323, including the elimination of onerous language that could have broadened physician liability in virtually every case where a patient dies. We were unable, however, to overcome the combined forces of the Governor's Office, the Georgia Sheriffs' Association and the Georgia Coroners' Association in their ultimately successful effort to place the medical examiner under the thumb of the GBI, rather than allowing the system to operate independently.

MAG was successful in *defeating* bills requiring licensure of acupuncturists and electrologists, extending chiropractic lab privileges, that attacked our 1987 Tort Reform gains (including the collateral source doctrine), decreasing chiropractic tort liability, and statutorily limiting fees a physician may charge a patient for copying medical records to name just a few.

A very special thanks to go Chester Lane, Executive Secretary of the Georgia Obstetrical and Gynecological Society, and Joe Sports, Legislative Representative for the Georgia Obstetrical and Gynecological Society, for their spirit of cooperation and tireless efforts working with MAG on the Healthy Baby Bill (SB 553). The success of this coordi-

nated venture between MAG and the OB-GYNs' specialty society is marked by our 40-to-12 victory in the Senate (in which half of the attorney-Senators voted *with* us!) and the subsequent establishment of a Governor's Blue Ribbon Commission charged with the investigation of the obstetrical crisis in Georgia and the examination of potential solutions. We are looking forward to a continuingly fruitful collaboration with Georgia's obstetricians and their representatives as we jointly set out to educate our Legislators and the public as to the dire need for an adequate resolution to the OB crisis in Georgia.

A "thank you" also goes to the MAG Mutual Insurance Company for their advice and able assistance on legislative matters again this year. Special thanks to Dr. Charles Hollis, Chief Executive Officer; Tom Gose, President; Joe McAbee, Vice-President of Claims; Marilyn Allen, Staff Attorney; and Robert Constantine, Corporate Attorney, for their long hours and dedicated service in the name of organized medicine.

As always, we have several agenda items — new and old — that we will be focusing on for next Session. We again plan to change the drug prescribing and dispensing laws to require that the brand name drug for which a pharmacist substitutes a generic be labeled as such so that patients will be better informed. Plans are also in the works to amend the pension laws to provide protection to pension assets. MAG will continue its efforts, in conjunction with the Georgia Society of Dermatologists, to find the best way of protecting consumers from the potential dangers posed by suntan equipment and tanning salons.

TEAMWORK PAYS! THANKS TO THE MANY PHYSICIANS AND AUXILIANS WHO WORKED HARD TO ENSURE A SUCCESSFUL SESSION.

Phone Bank

One of MAG's secret weapons is our Phone Bank, chaired this year by Mrs. Carolyn Moon. Dedicated Auxilians came in to MAG headquarters three days per week during the Session to staff the phones and inform physicians around the state about "hot" bills needing their attention and action. The Phone Bank was a pivotal resource in the lobbying effort for the Healthy Baby Bill in particular. The value of such a responsive grassroots communication with our Legislators by their constituent physicians and spouses cannot be overrated.

Doctor of the Day

MAG's Doctor-of-the-Day program was its usual roaring success this year, due to the generosity of so many of our physicians willing to donate a day away from their practice in service to Legislators, their staffs and others down at the Capitol. The usual parade of sore throats and upset stomachs was interspersed with a few more serious problems; we even had some impromptu surgery to remove precancerous lesions from one patient's back. Much of the credit for the success of our Doctor-of-the-Day program goes to Mrs. Alice Kaufmann, R.N., whose untiring work and unflaggingly cheerful disposition make us all proud to be associated with her. As a measure of her popularity, despite my many years involvement with legislation, I am now introduced at the Capitol as "Alice's husband."

Physician Involvement Program

The Physician Involvement Program (PIP) gave MAG a continuing strong presence at the Capitol this year, bringing Legislators face-to-face with concerned and knowledgeable physicians. Where our Doctor-of-the-Day program is strictly service oriented, PIP brings physicians and their spouses into the lobbying process by bringing them down to the Capitol, briefing them on the "hot" issues of the day and then contacting legislators to whom the PIP'ers address MAG's and their concerns.

Our victory in the Senate on the Healthy Baby Bill (SB 553) was due in no small part to the Auxilians who came down to the Capitol two days in a row and monopolized the hallway in front of the Senate chamber with their lobbying of Senate members . . . much to the consternation, we might add, of the trial lawyers who were effectively shut out of the hallway and the process!

As physicians and as citizens, our involvement in and responsibility for the political process cannot just start and end with the forty days of the annual Legislative Session, however. The months between now and next January offer unparalleled opportunities for forging relationships of trust and credibility with your Senator and Representative. To that end, it is incumbent on EVERY COUNTY AND DISTRICT MEDICAL SOCIETY to form a Legislative Committee, if it has not already done so, to coordinate Georgia physicians' grassroots political activity.

The logic is inescapable: a Legislator's constituents elect him or her, therefore it is in that Legislator's best interest to listen and be responsive to those constituents who display a continuing and informed interest in issues affecting them. This is particularly true when those constituents are physicians. First, physicians and their spouses are respected community leaders whose opinions may affect those of many other voters. Second, the complexity of many health care issues often demands that a Legislator turn to a trusted health care professional for advice and guidance.

Not only should this Legislative Committee bring its interested physicians to the Capitol to participate

(L to R): Roy W. Vandiver, M.D., DeKalb; Catherine S. Andrews, M.D., Cobb; and Joe C. Stubbs, M.D., South Georgia served on Reference Committee C.

in the PIP program *as a group*, but it should also direct its efforts toward establishing those lines of communication with its Legislators back home. This may mean having quarterly dinner-discussion groups or informal get-togethers, and sending local newsletters to Legislators for starters.

1990 Election Year Offers Major Opportunities for Physician Influence in the Political Process

The summer of 1990 will usher in profound political changes that will help shape the future of Georgia for many years to come. The main focus will naturally be the race for our next Governor. Under the Georgia Constitution, the Governor may hold that office for up to eight years; therefore, the person elected in 1990 may well serve through 1998. That individual will appoint every member of the Composite State Board of Medical Examiners, virtually every judgeship, and will clearly set the policies and agenda for our State as we enter the twenty-first century.

Of significant importance to physicians is this year's election of a new Lieutenant Governor, along with the 56 State Senators and the 180 State Representatives. The turnover in the State Senate, especially, is greater than at any time in recent history; thus, the opportunity for substantial changes in the character and direction of that body is unmatched.

I cannot overemphasize the importance of you getting *personally involved* in helping elect candidates with an open ear to organized medicine. Money is the lifeblood of political campaigns; the earlier and more generously you can donate to the candidate of your choice, the easier it is for him or her to collect additional financial support. Perhaps you think you can't give as much as you would like. You can sponsor a fundraiser in your home or through your community instead, gathering supporters whose collective contribution can make quite an impression with a candidate. Or you might like to make your office available for after hours phone banks or mass-mailing operations. The opportunities to help candidates are bountiful.

Individual financial contributions to candidates are very important, but money is not the only resource a campaign needs to thrive. Your time and energy spent on the phone or making campaign flyers available to your patients can be equally valuable to your candidate's campaign. As community leaders, physicians and their spouses are often admired. A willingness to put your name on the line for a candidate you believe in can be just the stamp of approval to draw in needed votes. More than any other activity, MAG's Council on Legislation urges the MAG membership to get involved in campaign

work this summer and fall. The Primary Election will be held on July 17, 1990, with any run-offs to be held on August 7, 1990. The General Election will be on November 6, 1990.

The MAG Council on Legislation looks forward to working with you, the heart and soul of MAG, toward achieving the delivery of quality health care in Georgia.

Recommendations

1. That MAG's Legislative Council and the Public Relations Committee work in concert with the Georgia Blue Ribbon Obstetrical Crisis Commission to educate Legislators and the public on the need and the means for a resolution to Georgia's obstetrical crisis.

2. That MAG work with interested parties before the convening of the 1991 General Assembly to develop an acceptable version of legislation calling for basic coverage group health insurance policies for small employers with optional benefits offered but not mandated.

3. That MAG work to pass legislation requiring a change in drug prescribing and dispensing laws so that when a pharmacist substitutes a generic drug for a brand name drug, that the label specifically designate the substitution and both the generic and brand names.

4. That MAG work to pass legislation modifying state pension laws so as to protect pension assets and income from attachment or garnishment.

5. That MAG continue to work with the Georgia Society of Dermatologists to regulate or otherwise control the use of suntanning equipment and the operation of tanning parlors so as to protect Georgia's consumers from the potential health threat inherent therein.

6. That Mrs. Carolyn Moon and the Auxilians who participated so effectively in the 1990 Phone Bank be highly commended for their vital contribution to MAG's legislative efforts.

7. That all members of the Auxiliary who participated as Phone Bank volunteers be written thank you letters by the Legislative Council Chairman.

8. That the Physician Involvement Program (PIP) continue its essential role in the legislative process by encouraging increased participation among members and Auxilians.

9. That every component medical society establish a Legislative Committee, if it has not already done so.

10. That each component medical society's Legislative Committee be responsible for bringing a group of its physicians to the Capitol to participate *as a group* in the PIP program at least once during the 1991 General Assembly.

11. That each component medical society's Legislative Committee should sponsor at least one function for its physicians and local Legislators *before* the convening of the 1991 General Assembly.

12. That the Legislative Council urge MAG membership to participate in campaign activities during the 1990 election year.

13. That MAG reinstitute its prior practice of sponsoring trips to Washington, D.C. by physician groups for the purpose of conveying our concerns about health care legislation to our Congressional delegation.

HOUSE ACTION

Adopted Recommendations 1, 6-12 with commendation.

Adopted Recommendation 2 as amended: "That MAG work with interested parties before the convening of the 1991 General Assembly to develop an acceptable version of legislation calling for basic coverage group health insurance policies for small employers."

Adopted Recommendations 3, 4, and 5.

Referred Recommendation 13 to the MAG Board of Directors for action.

MEDICAL ASPECTS OF SPORTS COMMITTEE

Letha Hunter-Griffin, M.D.

Refer to Reference Committee B for the complete text of the report of the Medical Aspects of Sports Committee.

Recommendations

1. That the Medical Aspects of Sports Committee supports MAG's position opposing legislation allowing therapists to evaluate and treat without physician referral.

2. That the Medical Association of Georgia favor the pursuit of continued efforts at establishing high school coach certification in medical aspects of sports within the state of Georgia. *(Referred to Reference Committee B.)*

3. That the Medical Association of Georgia support the presence of certified athletic trainers within the secondary school system. *(Referred to Reference Committee B.)*

4. That the Medical Association of Georgia should continue to encourage physician coverage of high risk sporting events at the high school level. *(Referred to Reference Committee B.)*

House Action

Adopted Recommendation 1.

RESOLUTION 1

Law Regarding Blood Alcohol Levels

DeKalb Medical Society, Inc.

Whereas, under current Georgia law the blood alcohol concentration (BAC) at which one is presumed to be under the influence of alcohol is 0.10 grams; and

Whereas, under current Georgia law the BAC at which it is conclusively illegal to drive a motor vehicle is 0.12 grams; and

Whereas, numerous studies have shown that impairment effects are seen in some persons at alcohol concentrations below 0.04 and that all persons are impaired to some extent at concentrations of 0.08 grams; and

Whereas, under current Georgia and Federal law operators of trucks, buses, boats, private aircraft and commercial aircraft are held to a 0.04 BAC; and

Whereas, drivers with BAC's of 0.05 grams to 0.10 grams are significantly represented in road crash statistics; and

Whereas, the American Medical Association has recommended that all states pass legislation setting 0.05 as the presumptively unlawful BAC for drivers; now, therefore be it

RESOLVED, that the Medical Association of Georgia urge the General Assembly of Georgia to change existing law so as to lower the conclusive blood alcohol concentration level from 0.12 grams to 0.08 grams and lower the presumptive BAC level from 0.10 grams to 0.05 grams; and be it further

RESOLVED, that a copy of this resolution be forwarded to appropriate leaders in the House and Senate as well as to Governor Joe Frank Harris and to his successor.

HOUSE ACTION

Adopted the first RESOLVED as amended:

"RESOLVED, that the Medical Association of Georgia petition the Georgia General Assembly to consider reevaluating the current law regarding Blood Alcohol Concentration (BAC) and motor vehicle operation, with the possible lowering of the present limits, both presumptive and conclusive, after considering scientific evidence on the effect of various BACs."

Adopted the second RESOLVED.

RESOLUTION 2

Honorary Dues-Exempt Status for Physicians in High Elected or Appointed Offices

DeKalb Medical Society, Inc.

Whereas, it is an infrequent honor for a MAG member to serve in a prominent national office as do Dr. Louis Sullivan, who is presently Secretary of the Department of Health and Human Services, and Dr. J. Roy Rowland, Congressman representing Georgia's 8th District; and

Whereas, MAG and the respective county medical societies, should establish dues-exempt categories of membership for these unique individuals; now, therefore be it

RESOLVED, that the House of Delegates grant honorary, dues exempt membership status to Drs. Louis Sullivan and J. Roy Rowland.

HOUSE ACTION

Adopted as amended: "RESOLVED, that the House of Delegates grant honorary dues exempt membership status to Drs. Louis Sullivan and J. Roy Rowland while in office."

RESOLUTION 10

Profit by Referral

John D. Watson, Jr., M.D.

Whereas, the image and credibility of American Medicine is declining steadily in the eyes of the public; and

Whereas, the major reason for this decline is related to the cost of medical care and the perception of over-utilization of tests and procedures to the inappropriate enrichment of the physician; and

Whereas, there is documentation of significantly increased utilization of facilities and procedures in facilities which have physician investors to which they are able to refer; and

Whereas, continued abuse of this nature and continued decline of the trust in physicians as the advocate for the patient may well lead us into a National Health Program; now, therefore be it

RESOLVED, that the Medical Association of Georgia consider ownership by either physicians, or their family members, of diagnostic or therapeutic facilities to which they refer to be unethical and detrimental to the healthcare of the nation. Exception should be made for re-

MAG members sit in on the proceedings of the Reference Committee. Chairman of MAG's Board of Directors, Dr. Tom Anderson, of Atlanta, is shown front and center.

mote rural facilities without which citizens would otherwise be deprived of needed services; and be it further

RESOLVED, that this resolution be forwarded to the American Medical Association for consideration by its 1990 House of Delegates as a policy position of that body.

HOUSE ACTION

Did not adopt.

RESOLUTION 11

Universal Access to Health Care

Bibb County Medical Society

Whereas, it is stated that some 25 to 35 million Americans do not have access to health care; and

Whereas, lack of access of health care is a major cause of calls for reform of the American health care system; and

Whereas, the State of Oregon has developed a plan to address universal access to health care; now, therefore be it

RESOLVED, that the Legislative Committee of MAG study the Oregon plan; and be it further

RESOLVED, that the Legislative Committee make a recommendation concerning possible similar legislation in Georgia to the MAG Board of Directors at its September 1990 meeting.

HOUSE ACTION

Adopted the following substitute RESOLVED: "RESOLVED, that the MAG Board of Directors study the Oregon Basic Health Services Act of 1989 and consider the feasibility of similar legislation for Georgia, reporting the results of their study at the September, 1990 Board of Directors meeting."

RESOLUTION 13

Non-Discrimination Against Victims of Illness

Medical Association of Atlanta

Whereas, Medical research evidence accumulated over the years indicates that many so-called "mental-illnesses" are caused by physical or physiological alterations in brain neurochemistry; and

Whereas, examples of such illnesses, previously thought to be the result of a weakness of character or morals, include General Paresis (Tertiary Syphilis), Major Depression, Schizophrenia, Tourette's Syndrome, Bipolar Disorder, Partial Complex Seizure Disorder, Obsessive-Compulsive Disorder; and that these illnesses respond favorably to medical management including medication and medical psychotherapy; and

Whereas, patients currently suffer from discrimination at the hands of their insurance carriers based upon the post-graduate training of the physician they consult for treatment, and that such discrimination penalizes patients for factors beyond their control; and

Whereas, the result of this discrimination is needless suffering, inadequate treatment, increased financial burden to the taxpayer, and decreased availability of care; and

Whereas, it is the perception of the Medical Association of Atlanta that various mandated health care coverage provisions result in inordinate and non-competitive price increases in health insurance coverage; now, therefore be it

RESOLVED, that the Medical Association of Georgia support equal and non-discriminatory insurance coverage of all illnesses recognized in the International Classification of Diseases — 9 (ICD-9) Clinical Modification and that the Medical Association of Georgia instruct the Legislative Council to pursue legislation in support of non-discriminatory major medical insurance coverage as part of its efforts to decrease the amount of mandated insurance benefits.

HOUSE ACTION

Adopted.

RESOLUTION 15

PRO Immunity

Bibb County Medical Society

Whereas, PRO activities can profoundly affect a physician's practice; and

Whereas, PRO's are businesses and *not* peer review organizations; and

Whereas, some PRO employees receive merit raises based on numbers of sanctions achieved and not the number of cases properly resolved; and

Whereas, PRO's should be held legally accountable for their actions; and

Whereas, PRO reviewing physicians are giving professional medical opinions that constitute the practice of medicine whenever they reach a decision about a particular case and should be held responsible for those medical decisions; now, therefore be it

RESOLVED, that MAG petition the Composite State Board of Medical Examiners to adopt a Rule stating that physicians who review medical records for third parties and express an opinion as to the necessity of a service or quality of the treating physician's care should be considered to be practicing medicine and under the authority of the Board; and be it further

RESOLVED, that the American Medical Association sponsor legislation prohibiting PRO employees' raises being based upon the number of sanctions achieved and requiring full PRO legal accountability for their actions; and be it further

RESOLVED, that the Georgia Delegation submit such a resolution to the AMA House of Delegates at its 1990 annual meeting seeking Federal legislation establishing a ban on PRO employee raises being based upon the number of sanctions achieved, and seeking Federal legislation requiring full PRO legal accountability for their actions.

HOUSE ACTION

Referred to MAG Board of Directors.

RESOLUTION 19

Geographical Variances in Medicare Reimbursement

Bibb County Medical Society

Whereas, Medicare and private insurance companies currently recognize a number of different geographic areas in Georgia and maintain among them different reimbursement levels for physician services; and

Whereas, many rural Georgia physicians suffer discrimination from these arbitrary, geographic differentiations in their third party reimbursement; and

Whereas, Georgia physicians practicing in their respective specialties should be reimbursed at a uniform level, regardless of their practice locality within the state; and

Whereas, lower reimbursement rates for rural physicians serve as a disincentive for new physicians to establish practices in these underserved areas; and

Whereas, the new RBRVS mechanism of physician payment is supposed to eliminate such intrastate geographic differentiation in reimbursement; now, therefore be it

RESOLVED, that the Medical Association of Georgia monitor the implementation of the RBRVS in Georgia to ensure the elimination of intrastate, intraspecialty differences in MEDICARE reimbursement rates; and be it further

RESOLVED, that MAG seek the assistance of the Georgia Congressional delegation to take appropriate remedial action if RBRVS fails to eliminate such differences; and be it further

RESOLVED, that MAG introduce legislation to eliminate such geographic intraspecialty differences in insurance companies' reimbursement to Georgia physicians.

HOUSE ACTION

Adopted the following substitute RESOLVED in lieu of original three RESOLVED portions: "RESOLVED, that MAG urge Congress to expeditiously eliminate Medicare physician payment differentials that do not reflect valid and demonstrable variations in physician overhead and professional liability insurance."

RESOLUTION 24

Non-Emergency Transport Services

Laurens County Medical Society

Whereas, the availability of Medicaid funding several years ago led to the development of a number of commercial enterprises specializing in non-emergency transportation of indigent patients to hospitals and physicians' offices; and

Whereas, the proliferation of such enterprises, possible abuses concerning their utilization, and the inability of physicians to investigate possible abuse before signing for authorization have led to significant problems for the State Department of Medical Assistance (Medicaid) and for physicians; now, therefore be it

RESOLVED, that MAG urge the Georgia Department of Medical Assistance to increase its monitoring of non-emergency transportation services in the state and to take appropriate corrective action in those cases where unprofessional activity is leading to abuse of the system.

HOUSE ACTION

Adopted with commendation.

RESOLUTION 25

Generic Drugs

James Q. Whitaker, M.D.

Whereas, a number of generic drugs have been found to be inferior in efficacy to brand name pharmaceuticals despite claims to their equivalency; and

Whereas, Georgia law requires pharmacists to obey physicians' instructions when "brand necessary" is written as part of the prescription; and

Whereas, the Drugs and Narcotics Agency and other enforcement agencies have not made enforcement of this law a priority, resulting in a number of alleged cases of unauthorized and illegal pharmaceutical substitution; and

Whereas, some third party reimbursers are attempting to coerce pharmacists to inappropriately substitute for the cheapest drug product without physician authorization; now, therefore be it

RESOLVED, that the Medical Association of Georgia convey to the State Pharmacy Board and the Drugs and Narcotics Agency its insistence that adequate steps be taken to ensure Georgia pharmacists' compliance with the law against unauthorized generic substitution; and be it further

RESOLVED, that MAG introduce legislation 1) requiring pharmacists to notify both the patient and physician by telephone, in person, or by written notice of any drug substitution; and 2) specifying that failure by a pharmacist to notify the physician and/or patient shall be punishable as a misdemeanor.

HOUSE ACTION

Adopted the first RESOLVED portion.

Did not adopt the second RESOLVED portion.

RESOLUTION 29

ATV Licensure and Age for Marketing

Alfred L. Davis, Jr., M.D.

Whereas, the Federal Consumer Product Safety Commission has decided that all types of three and four-wheel all-terrain vehicles (ATVs) made for children, as well as all three-wheeled recreational ATVs are "imminent hazards" as defined by the Federal Consumer Product Safety Act; and

Whereas, most ATVs have only three wheels; and

Whereas, the Consumer Product Safety Commission has asked the United States Department of Justice to find that certain all-terrain recreational vehicles are hazardous; and

Whereas, a high percentage of deaths and costly injuries associated with ATVs have involved children and teenagers; now, therefore be it

RESOLVED, that the Medical Association of Georgia seek legislation requiring motor vehicle licensure of ATVs; and be it further

RESOLVED, that MAG convey to commercial firms selling ATVs in Georgia the dangers of such vehicles to Georgia's youth, calling upon such firms to direct their marketing and sales only to persons 16 years of age or older. *(Referred to Reference Committee D.)*

HOUSE ACTION

Did not adopt.

RESOLUTION 34

Congressional Lobbying

Edward D. Himot, M.D.

Whereas, the Congress of the United States has passed legislation that restricts freedom of physicians to practice medicine as they have been trained to do; and

Whereas, there has been in the past and will be further legislation proposed to restrict and penalize physicians trying to practice proper medicine; and

Whereas, there has been legislation that would restrict physicians from investing in private enterprise ventures because they are physicians; and

Whereas, the AMA lobby has not been effective in preventing legislation that is anti-doctor; now, therefore be it

RESOLVED, that MAG make an independent effort concerning lobbying on a Congressional level, either independently or in concert with other state medical societies.

HOUSE ACTION

Did not adopt.

RESOLUTION 36

Right to Privacy in Termination of Pregnancy

Georgia Delegation to the American Medical Association

Whereas, there has been a profound and gratifying reduction in maternal morbidity and mortality in the years since the 1973 Supreme Court ruling on abortion *(Roe v. Wade)*; and

Whereas, laws restricting abortion have been singularly ineffective; and

Whereas, such laws have been a direct cause of injury and death to pregnant women at the hands of criminal abortionists; and

Whereas, MAG views any effort to interfere with the privacy of the doctor-patient relationship as inappropriate; now, therefore be it

RESOLVED, that the Medical Association of Georgia support the position that no government nor governmental agency should be interposed between a patient and her physician with regard to the termination of a pregnancy; and be it further

RESOLVED, that the Medical Association of Georgia support the position that the early termination of pregnancy is a medical matter between the patient and the physician, to be performed only by a duly licensed physician in conformance with the standards of good medical practice and the laws of the state of Georgia, subject to the physician's clinical judgment, the patient's consent, and the availability of appropriate facilities; and be it further

RESOLVED, that the Medical Association of Georgia support the position that no physician nor other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles.

HOUSE ACTION

Adopted.

RESOLUTION 38

Abortion

David Fern, M.D.

Whereas, the practice of medicine is a healing art and the taking of life works against this end; and

Whereas, the healing goal is at the heart of the integrity of medicine; and

Whereas, medicine ought to fear the potential consequences to society and to its own image in allowing abortions to be done without good cause; and

Whereas, 97% of abortions are performed for reasons other than rape, incest or protecting the life of the mother; and

Whereas, medicine should stand for life whenever possible; and

Whereas, there are many other ways of solving the problems of unwanted pregnancies other than abortion; and

Whereas, many fellow citizens are trying to conceive without results and would be willing to adopt; now, therefore be it

RESOLVED, that MAG go on record in opposition to the practice of abortion for the reasons of convenience, gender selection, and/or as a means of birth control.

HOUSE ACTION

Did not adopt.

RESOLUTION 40

Freedom of Choice in Health Insurance

Ralph A. Tillman, M.D.

Whereas, the 1989 House of Delegates referred Resolution 32 (dealing with Freedom of Choice in Health Insurance) to the Third Party Payors Committee; and

Whereas, other serious problems during the year consumed most of the time and attention of this committee; and

Whereas, the problem dealt with in this Resolution continues to worsen instead of getting better; now, therefore be it

RESOLVED, that the Medical Association of Georgia work through the Third Party Payors Committee, and Legislative Council to develop an approach to provide "basic health care needs" and various options of insurance coverage at a cost that individuals, businesses and other entities can afford.

HOUSE ACTION

Adopted.

RESOLUTION 41

State Coroner and Medical Examiner System

Muscogee County Medical Society

Whereas, the Muscogee County Medical Society petitioned the Medical Association of Georgia by resolution in the Spring of 1989 to effect the abolishment of the Coroner's system in Georgia; and

Whereas, the General Assembly of the State of Georgia passed a bill during the 1990 Session that will restructure the Coroner & Medical Examiner system and will place the State Medical Examiners Office under the Georgia Bureau of Investigation (GBI); and

Whereas, the placing of the State Medical Examiner's Office under the authority of the GBI is at odds with national standards of death-investigation in that it presents the perception of a conflict of interest; and

Whereas, the State Medical Examiners Office should be independent from any law enforcement agency; and

Whereas, the proper implementation of this law, to achieve its intended benefit to the people of this State, will not only require adequate funding either through the general budget or, preferably, on a capitation basis, but also will require the advice and participation by the medical profession; now, therefore be it

RESOLVED, that MAG shall approach the next Session of the General Assembly of the State of Georgia to revise the State Medical Examiners system to place it under the authority of a non-law enforcement agency or department; and be it further

RESOLVED, that the Medical Association of Georgia immediately provide counsel as to the appropriate funding for such a Medical Examiners System to whichever state agency is designated as responsible for the implementation of the provisions of the new law; and be it further

RESOLVED, that the Medical Association of Georgia offer advice and assistance in the future development of the system as enacted by the General Assembly to whichever state agency will be designated as responsible for the new law's implementation.

HOUSE ACTION

Adopted with commendation.

RESOLUTION 42

Including Psychiatry in the State Medical Education Board's Program

Medical Student Section

Whereas, the State of Georgia has recognized a specific need and desire for psychiatrists to practice in the State's rural communities; and

Whereas, the Loan Repayment Program recently authorized by state and federal legislation, which elected to include psychiatry as a needed and desired discipline for the rural areas of Georgia, serves as evidence of this support; and

Whereas, the State Medical Education Board Scholarship availability does not reflect this support by including psychiatry among the specialties preferred for scholarship commitments in "underserved areas"; now, therefore be it

RESOLVED, that the Medical Association of Georgia support the inclusion of psychiatry among the other primary care disciplines eligible for the State Medical Education Board Scholarships.

HOUSE ACTION

Adopted by substitute: "RESOLVED, that MAG encourage the utilization of presently existing programs and work toward the development and implementation of additional programs to encourage psychiatrists to locate and practice in underserved areas."

RESOLUTION 43

Physician-Patient Confidentiality in UR

Ralph L. Haynes, M.D.

Whereas, many insurance agencies insist on calling practicing physicians, demanding information regarding hospitalized patients, despite the availability of hospitalization review nurses in hospitals to answer such inquiries; and

Whereas, the recently enacted Utilization Review Regulation Act (HB 1813) allows a physician to designate other personnel as his/her contact for UR companies; and

Whereas, significant concerns remain as to the confidentiality of the physician-patient relationship when UR companies insist on knowing the patient's diagnosis,

current management, complications, etc.; now, therefore be it

RESOLVED, that MAG introduce additional legislation to require that any insurer or entity working on behalf of any insurer seeking information on a patient's condition 1) submit a signed authorization from patients to each physician from whom they wish information, specifying either the reviewer with which the physician is entitled to discuss this information, or the established utilization review process of the hospital and 2) be limited to only that information pertinent to that claim — not a complete patient history file.

HOUSE ACTION

Did not adopt.

RESOLUTION 45

Amending the Living Will Law

Medical Association of Atlanta

Whereas, the Georgia General Assembly has enacted a Living Will law, recognizing the right of a competent adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition; and

Whereas, Georgia's Living Will Statute presently includes language limiting the availability of the living will form in hospitals and other health care facilities to those patients specifically requesting such forms; and

Whereas, Georgia's Living Will statute excludes from its definition of "life-sustaining procedures" the administration of nourishment; and

Whereas, these aspects of the current Living Will statute are not in the best interest of patients; now therefore be it

RESOLVED, that the Medical Association of Georgia seek to have introduced in the 1991 Georgia General Assembly legislation that will:

1. amend the definition portion of the statute by deleting "(A) Nourishment" from the listed exclusions, thereby allowing nourishment to fall within the definition of "life-sustaining procedure"; and
2. amend the definition portion of the statute to delete the current requirement for two physicians' concurring written opinion following examination of the patient, that death is "imminent"; and
3. amend Code section 31-32-9, paragraph (d), of the Living Will statute to allow hospitals, skilled nursing facilities, and other medical or health care facilities to expand the availability of the Living Will forms by deleting the language that requires a patient's request prior to giving the patient a living will.

HOUSE ACTION

Three component parts of the RESOLVED section were considered separately:

1. Adopted.
2. Adopted as amended: "Amend the definition portion of the statute to delete the current requirement that death is 'imminent'; and"
3. Adopted.

RESOLUTION 46

Precertification for Medicaid

Joseph P. Bailey, Jr., M.D.

Whereas, preadmission certification for Medicaid patients is not proven to be a cost-effective measure; and

Whereas, the pre-certification requirement can limit or delay necessary treatment for Medicaid patients, thereby creating, in effect, a two-tiered medical services delivery system in Georgia; and

Whereas, such a requirement is just another in the series of obstacles physicians must overcome in their treatment of Medicaid patients; and

Whereas, Georgia's physicians are still caring for the State's Medicaid patients in spite of other hindrances such as the failure to increase Medicaid reimbursement rates for several years; and

Whereas, Georgia's physicians do not need further bureaucratic dissuasion from serving this patient population; now, therefore be it

RESOLVED, that MAG institute immediate efforts to have the Department of Medical Assistance rescind its Medicaid preadmission certification requirements.

HOUSE ACTION

Adopted with commendation.

RESOLUTION 50

MAG Policy on Abortion

Ralph A. Tillman, M.D.

Whereas, the policy on abortion as established by the Executive Board of the American College of Obstetricians and Gynecologists is as follows:

> "It is recognized that abortion may be perfromed at a patient's request, or upon a physician's recommendation. No physician should be required to perform nor should any patient be forced to accept an abortion"; and

Whereas, the 7th edition of the American College of Obstetricians and Gynecologists Standards clearly and succinctly addresses the unwanted pregnancy issue and outlines the options about which the physician should counsel the patient (Family Planning, p. 62) as well as the standards of care for abortion services if the properly counseled patient chooses that option (Abortion, p. 68); and

Whereas, the current Georgia Statutes embodies the aforementioned principles and standards of care (O.C.G.A. 16-12-141); and

Whereas, the Georgia Obstetrical and Gynecological Society has affirmed the policy and standards of care as developed by the American College of Obstetricians and Gynecologists and has further recommended that the Medical Association of Georgia oppose any bill that would produce any significant or appreciable change in the current Georgia Statutes regarding abortion; now, therefore be it

RESOLVED, that the Medical Association of Georgia House of Delegates hereby affirm the policy on abortion of the Georgia Obstetrical and Gynecological Society and adopt it as the official policy of the Medical Association of Georgia.

HOUSE ACTION

Filed.

RESOLUTION 51

TITLE X, The Population Research and Voluntary Family Planning Program

Ralph A. Tillman, M.D.

Whereas, Title X was signed into law in 1970 and is administered by the Department of Health and Human Services to authorize grants to public and non-profit organizations for the provision of family planning services; and

Whereas, Health and Human Services' Regulations currently prohibit physicians at Title X funded family planning clinics from providing abortion information and referrals to clinics for abortions, even when such information is specifically requested; now, therefore be it

RESOLVED, that the Medical Association of Georgia seek support form the Georgia Congressional Delegation to develop and aggressively support legislation that would override the Health and Human Services Regulations prohibiting the Title X family planning clinics from providing abortion information and referrals.

HOUSE ACTION

Adopted.

RESOLUTION 52

Investigation of Quick Weight Loss Programs

Thomas Anderson, Jr., M.D.

Whereas, some quick weight loss centers appear to be understaffed and do not provide adequate medical supervision; and

Whereas, some quick weight loss diets appear to be dangerous; and

Whereas, many people have been injured as indicated by the 18 people in Florida who had to have surgery after undergoing quick weight loss programs; now, therefore be it

RESOLVED, that MAG support legislative studies and possible legislation to regulate quick weight loss programs.

HOUSE ACTION

Adopted.

RESOLUTION 53

Threat of Physician Certificate of Need

David Allen, M.D.

Whereas, the Georgia General Assembly's "Blue Ribbon" Access to Health Care Commission has been established to make recommendation to the state government regarding a wide range of cost containment and access issues; and

Whereas, a current recommendation under serious discussion by the Commission is that physician-owned outpatient diagnostic and treatment services (e.g., lithotripters, MRI's, etc.) be brought under the State Certificate of Need law in the same manner as are presently hospital-owned services; now, therefore be it

RESOLVED, that the Medical Association of Georgia oppose efforts to include privately owned outpatient diagnostic and treatment services among those entities, such as hospital owned services, which presently come under the State Certificate of Need law.

HOUSE ACTION

Adopted as amended: "RESOLVED, that the medical association of Georgia oppose efforts to include privately owned outpatient diagnostic and treatment services among those entities, such as hospital owned services, which presently come under the State Certificate of Need law and continue MAG's efforts to repeal the Certificate of Need law in the State of Georgia."

RESOLUTION 55

Physician-Patient Relationship

Elizabeth N. Clark, M.D.
Thomas E. Price, M.D.

Whereas, the subject of abortion is extremely controversial and personal; and

Whereas, any questions regarding medical treatment should remain protected by physician-patient confidentiality; and

Whereas, present Medical Association of Georgia policy and Georgia state law support this relationship; and

Whereas, any attempt to change present policy would be detrimental to the physician-patient relationship and to the standard practice of medicine; and

Whereas, the membership of the Medical Association of Georgia should be notified regarding any possible attempt at infringement on their practices; now, therefore be it

RESOLVED, that the Medical Association of Georgia reaffirm its support for its present policy regarding abortion and the physician-patient relationship; and be it further

RESOLVED, that any proposed legislation in the Georgia State Legislature relating to the subject of abortion or restricting physician-patient confidentiality be communicated to the Medical Association of Georgia membership in its legislative bulletin in a timely fashion.

HOUSE ACTION

Filed first RESOLVED section.

Adopted second RESOLVED section.

RESOLUTION 56

Proposal to Amend the Omnibus AIDS Act

Robert D. Gongaware, M.D.

Whereas, AIDS is a fatal disease caused by the HIV virus and communicable through contact with body fluids of infected persons, including those who are asymptomatic; and

Whereas, health care providers are at a significantly greater risk than the general population of coming in contact with bodily secretions of patients who have the HIV virus; and

Whereas, testing for this virus is often a part of the evaluation of patients who are considered at high risk or even possible risk for having the virus; and

Whereas, current law requires a detailed statement regarding the purposes of the test and the risks of the test itself; and

Whereas, patients may decide to refuse testing; and

Whereas, this refusal may place health care workers at higher risk; and

Whereas, many portions of the explanation regarding this disease process need not or may not be discussed with certain patients; now, therefore be it

RESOLVED, that the Medical Association of Georgia seek to amend the Omnibus AIDS Act to provide:

1. that physicians be permitted to test high risk individuals and individuals for whom the risk factor is unknown for the HIV virus as a means of evaluating their patients in an appropriate fashion as well as providing protection to health care providers;

2. that physicians be permitted to test for the virus in an appropriate fashion, utilizing their professional judgment, without the necessity of obtaining informed consent of the patient prior to testing;

3. that physicians and other health care professionals utilize reasonable historical medical standards to counsel patients regarding the implications of HIV testing prior to the test; and

4. that physicians and health care providers utilize strict criteria to maintain patient confidentiality regarding HIV testing.

HOUSE ACTION

Referred to MAG Board of Directors.

Report of Reference Committee D

Reference Committee D gave careful consideration to eight referred reports and resolutions. The following physicians were members of that Committee: Alan L. Plummer, Chairman, Medical Association of Georgia; Dan B. Stephens, Vice Chairman, Cobb; Robert A. Burns, Whitfield-Murray; L.T. Crimmins, Dougherty; Robert D. Gongaware, Georgia Medical Society; Michael E. Green, Bibb; Thomas L. Haltom, Cobb; John P. Heard, DeKalb; Richard A. Wherry, Lumpkins. MAG Staff, Steve Davis, Director of Education.

ACCESS TO MEDICAL CARE COMMITTEE

M. Julian Duttera, M.D., Chairman

Refer to Report of Reference Committee B for the complete report of the Access to Medical Care Committee.

Recommendations

1. That MAG and county societies work with the MAG Auxiliary toward changing the focus of Doctors Day (March 30) toward efforts to attract high school and colleges level students into the practice of medicine.
2. That county medical societies offer the services of an advisory committee to the pre-med advisors in the local community colleges to help encourage students to go into medicine.
3. That MAG study the AMA Health Access America campaign with the aim of developing specific recommendations to improve access to medical care in Georgia. *(Referred to Reference Committee B.)*

HOUSE ACTION

Adopted first RESOLVED as amended: "That the MAG and county societies work with the MAG Auxiliary to augment Doctors' Day activities by encouraging people to enter the practice of medicine, as one of the Auxiliary's community service activities."

Adopted second RESOLVED as amended: "That county medical societies offer the services of an advisory committee to the career counselors in local high schools and colleges to help encourage students to go into medicine; and that such physician committees employ medical students and young physicians in these activities, as well as utilize informational materials available through the American Medical Association's Medical Student Section and Young Physicians' Section."

Alan Plummer, M.D., from the Medical Association of Atlanta, was Chairman of Reference Committee D.

RESOLUTION 12

National Practitioner Data Bank

Bibb County Medical Society

Whereas, the National Practitioner Data Bank is law; and

Whereas, the National Practitioner Data Bank is scheduled to be implemented as of April 2, 1990; and

Whereas, the National Practitioner Data Bank will have implications for every practicing physician; and

Whereas, it is incumbent on MAG to explain these implications to our members; now, therefore be it

RESOLVED, that MAG develop an educational program to be carried out at the State and County level to inform Georgia physicians about the National Practitioner Data Bank.

HOUSE ACTION

Adopted with commendation.

RESOLUTION 17

Community Service

Medical Association of Atlanta

Whereas, President Bush on March 6, 1990, challenged all associations in the nation to put community service at the center of their agendas; and

Whereas, he further challenged the members of all associations, a combined total of 100 million Americans, to make community service their personal mission; and

Serving on Reference Committee D were (L to R): Robert A. Burns, M.D., Whitfield-Murray; L.T. Crimmins, M.D., Dougherty; and Dan B. Stephens, M.D., Vice-Chairman, Cobb.

Whereas, associations have the collective resources, expertise and energy to solve drug abuse, homelessness, hunger, illiteracy and many other problems threatening our society; and

Whereas, relatively few associations across the country are engaged in community service programs such as the MAA free health care clinic for the homeless; now, therefore be it

RESOLVED, that all component societies and members of the Medical Association of Georgia accept the challenge of President Bush to participate in community service programs in the coming years.

HOUSE ACTION

Adopted with commendation.

RESOLUTION 18

Medical Family

Medical Association of Atlanta

Whereas, programs addressing the concerns surrounding the health of the medical family had a low priority for organized medicine; and

Whereas, minimal programmatic effort has been extended toward the welfare of the medical family; and

Whereas, continuing medical education credit for success in stress management for the medical family has not been available; now, therefore be it

RESOLVED, that the Medical Association of Georgia take positive steps by creating an ad hoc committee to propose solutions to reduce stress involving the medical family through seminars and other vehicles; and be it further

RESOLVED, that continuing medical education credit should be available to encourage physicians to participate in preventative medicine for the medical family.

HOUSE ACTION

Adopted first RESOLVED as amended: "That the Medical Association of Georgia take positive steps to propose solutions to reduce stress involving the medical family through seminars and other vehicles . . ."

Adopted second RESOLVED.

Other members of Reference Committee D included (L to R): Richard A. Wherry, M.D., Lumpkin; Robert D. Gongaware, M.D., Georgia Medical; Michael E. Greene, Student, Bibb; John P. Heard, M.D., DeKalb; and Thomas L. Haltom, M.D., Whitfield-Murray.

RESOLUTION 27

Living Wills and Health Care Powers of Attorney

Louis H. Felder, M.D.

Whereas, many elderly patients would like to avoid many of the heroic measures often performed on patients who are apparently terminally ill or nearly terminally ill; and

Whereas, patients are not always sure how to go about making their wishes known in advance; and

Whereas, the medical profession has never mounted an extensive public campaign to encourage people to consider "Living Wills" and health care powers of attorney; now, therefore be it

RESOLVED, that the Medical Association of Georgia instruct its AMA Delegates to introduce a resolution into the AMA House requesting the Board of Trustees to suggest to all of its members, and state medical associations that they make information about Living Wills and health care powers of attorney continuously available in their patient reception areas.

HOUSE ACTION

Adopted as amended: "That the Medical Association of Georgia instruct its AMA Delegates to introduce a resolution into the AMA House requesting the Board of Trustees to encourage every state medical association to urge all physicians to make information about Living Wills and health care powers of attorney continuously available in their patient reception areas."

RESOLUTION 29

ATV Licensure and Age for Marketing

Alfred L. Davis, Jr., M.D.

Refer to Report of Reference Committee C for the complete text of Resolution 29.

RESOLVED, that the Medical Association of Georgia seek legislation requiring motor vehicle licensure of ATVs. *(Referred to Reference Committee C.)*

RESOLVED, that MAG convey to commercial firms selling ATVs in Georgia the dangers of such vehicles to Georgia's youth, calling upon such firms to direct their marketing and sales only to persons 16 years of age or older.

HOUSE ACTION

Adopted second RESOLVED as amended: "That MAG continue to stress the dangers of ATVs to Georgia youth."

RESOLUTION 30

Alcohol Abuse Education in Elementary Schools

Alfred L. Davis, Jr., M.D.

Whereas, data from the National Household Survey documents the startling fact that more than half of all youth aged 12 to 17 have consumed an alcoholic beverage at some time in their lives; and

Whereas, the American Medical Association has affirmed that youth, particularly those approaching the age of onset of risk (i.e., before middle school), should be the primary target of educational preventative efforts to instill the concept of personal responsibility for the initial decision to use or to refrain from use of alcohol, tobacco and drugs; now, therefore be it

RESOLVED, that MAG should prepare and distribute preventative and referral information on youth alcohol abuse for dissemination by physicians in office practices and public health clinics *(Referred to Reference Committee F);*

RESOLVED, that MAG should collaborate with the State Board of Education to see that appropriate anti-drug curricula are made more available in local elementary school systems.

HOUSE ACTION

Adopted second RESOLVED as amended: "That MAG should offer support to the State Board of Education and local school boards to see that appropriate anti-drug information is made available in local elementary school systems."

RESOLUTION 33

Medical Student Liability Coverage on Out-of-State Rotations

Medical Student Section

Whereas, elective rotations during the fourth year of medical school serve to enrich medical school education through exposure to different approaches to the practice of medicine; and

Whereas, the electives allow both the medical student and the academic institution opportunities to evaluate the possibility of a future residency assignment; and

Whereas, many institutions require liability coverage for visiting students but do not provide a means by which the student may procure the insurance within the institution's program; and

Whereas, a 1987 Georgia law exempts medical students within the state of Georgia from liability but makes no provisions for Georgia medical students who choose elective rotations in other states (approximately one-third of MCG students); and

Whereas, upon passage of the aforementioned law, the Medical College of Georgia, but not private medical schools within the state, discontinued providing opportunities for liability coverage of medical students; and

Whereas, the purchase of limited term (four to six week) liability insurance policy by an individual can be exorbitantly ($3,000 to $4,000 per month) and well beyond a medical student's means; and

Whereas, elective rotation should not be limited to in-state facilities or by the financial constraints of medical students who attend the state medical school; now, therefore be it

RESOLVED, that MAG propose possible solutions to the current discrepancies between opportunities available to private and public medical students and to consider asking that MAG Mutual make available limited term policies at a reasonable cost for state medical students who wish to participate in out-of-state electives.

HOUSE ACTION

Adopted as amended: "That MAG encourage the Medical College of Georgia to provide professional liability insurance coverage to medical students for their out-of-state clinical rotations."

RESOLUTION 44

Mandatory CME

Muscogee County Medical Society

Whereas, the Georgia General Assembly has passed a law requiring physicians to participate in at least forty hours of continuing medical education every two years as a condition of relicensure; and

Whereas, in enforcing this mandate, the Composite State Board of Medical Examiners will conduct random audits of Georgia physi-

cians, requiring them to present documentation of having participated in at least 40 hours of CME; and

Whereas, to qualify for the American Medical Association Physician's Recognition Award, a physican must report 150 credit hours of continuing medical education during a consecutive three-year period immediately preceding the date of the application; and

Whereas, in at least seven states with mandatory CME laws, state licensing boards will accept a current American Medical Association Physician's Recognition Award; and

Whereas, in 1979 the Medical Association of Georgia House of Delegates voted to set a goal of having all MAG members qualify for the AMA PRA; now, therefore be it

RESOLVED, that MAG urge the Composite State Board of Medical Examiners to enact regulations stating that a physician's presentation of a current American Medical Association Physician's Recognition Award shall be considered as acceptable documentation of his or her compliance with the CME law.

HOUSE ACTION

Adopted as amended: "That MAG urge the Composite State Board of Medical Examiners to enact Regulations stating that a physician's presentation of a current AMA Physician's Recognition Award or similar certificate offered through a national medical organization shall be considered as acceptable documentation of his or her compliance with the CME law."

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Report of Reference Committee

Reference Committee F was comprised of the following physicians: Joseph P. Bailey, Jr., Chairman, Richmond; H.G. Davis, Jr., Vice-Chairman, Worth; Sumner Fishbein, Richmond; Charles A. Lanford, Bibb; Gwynne T. Brunt, Jr., Medical Association of Atlanta; William D. Logan, Jr., Medical Association of Atlanta; and Walter M. Ligon, Cobb. MAG Staff, Karen Haughey, Director, Administration and Finance.

TREASURER'S REPORT

Cyler D. Garner, M.D., Treasurer

Each year I have emphasized the importance of the financial base which allows your Association to fulfill on-going membership needs and respond to critical issues like the Medicare/HealthCare Compare situation we faced this year. We had a successful year in the legislative arena and must continue to fund our legislative efforts if we are to be successful in the coming year.

Last year, we presented a balanced budget which did not include funding for a Medical Director for the Impaired Physicians Program. The House of Delegates adopted the recommendation of Reference Committee F to approve the budget as presented and to fund the position of Medical Director from the reserves of MAG until this year. This built-in deficit position from last year coupled with increased budget requests meant the Finance Committee had to make some difficult decisions — curtail current activities or recommend a dues increase.

The Finance Committee considered three approaches: a "bare bones" budget, a restored budget, and an optimum budget. The "bare bones" budget, which did not require a dues increase, eliminated the Impaired Physicians Program, allowed publication of only eleven issues of the *Journal*, cut television advertising from the Public Relations budget, eliminated two current vacant staff positions, provided no salary increases for staff, and denied the special allocation to the Auxiliary for forums for teen health and Older Persons with Active Life Styles. The Finance Committee concluded that this alternative did not provide the level of activity that we need from our Association. The Committee felt that for MAG to reduce the current level of legislative, legal, and public relations activities in the light of increasing assaults upon the medical profession would be not only inappropriate but also irresponsible.

The Finance Committee recommended a variation of the restored budget that included honoring budget requests for the *Journal*, Public Relations, and the Auxiliary

while reducing requests from some categories. The Impaired Physicians Program request was reduced by $26,964 mainly by providing part-time secretarial support and some support services from the Administration budget. To further minimize the dues increase needed, the Finance Committee also recommended that $75,000 be allocated from our Tort Reform Reserve to offset staff salaries and legislative expenses that are related to the tort reform activities. We will have a major tort reform effort this year, starting with the Governor's Blue Ribbon Commission on the obstetric crisis, and ending with the General Assembly where we hope to pass major tort legislation. A $40 dues increase, coupled with an intensive program spearheaded by Dr. Collins to recruit new members, will allow us to support this year's proposed budget.

Last year, I outlined our plan to evaluate administrative services. We have looked closely at our data processing systems and determined that the hardware and software should be replaced with a Personal Computer Local Area Network (PC-LAN) costing approximately $121,000 (bid of $109,941 plus 10% for unforeseen costs). Our Digital Equipment Corporation (DEC) minicomputer, purchased in 1985 for $211,751, is obsolete, expensive to maintain, and cannot even keep up the current word processing needs. The depreciation reserves of $186,611 from the DEC system are $65,000 more than the new system will cost.

The membership software which was developed in-house many years ago makes adding new information for the annual Directory as mandated by the House of Delegates last year extremely difficult. A PC-LAN will enable us to use the sophisticated but inexpensive software packages developed for the personal computer market. Association membership management software is available which will allow us to develop special use reports and add new data fields without time-consuming and expensive programming. Desk top publishing software has the potential to reduce printing costs. Maintenance costs will be reduced dramatically; currently we are spending $26,000 annually just to maintain the DEC equipment. Utilities should also be reduced since special air conditioning is not required for the PC-LAN. Finally the new system is easily and inexpensively expandable to meet future needs.

Joseph P. Bailey, Jr., M.D., (L) from Richmond County, served as Chairman of Reference Committee F. H.G. Davis, Jr., M.D., from Worth County, served as Vice Chairman.

Several improvements were made at MAG Headquarters this year, many of which will either lower costs or increase revenue. The new carpeting and repainting, authorized by last year's House of Delegates, made the office brighter and more cheerful. The carpeting was a special type of durable carpet tile which is used at the Atlanta airport and is expected to last twice as long as the old carpet. A great clean-up day, held shortly before the offices were painted, generated enough papers and trash to fill three 30-foot dumpsters. As a side benefit, the need to purchase more filing cabinets was avoided. A new telephone system provides better service, improves cost control of long-distance charges, and allows access to the staff after the switchboard is closed. In addition, it allowed us to eliminate over 18 private phone lines at great savings, which has been installed over the years to make up for the inadequacies of the old telephone system. The utility pole, which made turning into the driveway a dangerous adventure, was moved by Georgia Power at no cost to MAG. Improvements were made to the parking deck lighting to improve security and to the automatic gates to increase reliability. With these improvements in place, we were able to increase the parking space rental rates and generate additional income.

Gwynne T. Brunt, M.D., (left) Medical Assn. of Atlanta; and Walter M. Ligon, M.D., Cobb, served on Reference Committee F.

My last six years serving as your Treasurer have been rewarding. The financial position of MAG has improved greatly with the implementation of prudent fiscal policies — presenting balanced budgets, increasing dues when they need to be, and setting aside cash reserves to replace equipment when needed. During my term in office, I have emphasized cost reduction strategies that would not impair the quality or level of service provided to our members. I am confident that these policies will continue during the coming years.

CHAIRMAN OF THE BOARD OF DIRECTORS

Thomas J. Anderson, Jr., M.D.

Presented below is the Fiscal Year 1990-1991 MAG budget as recommended by the Board of Directors:

BUDGET RECOMMENDATIONS FISCAL YEAR ENDING MAY 31, 1991

1. Regular dues should be increased from $360 to $400 per year. Other categories that are a percentage of regular dues should be increased proportionately to the nearest dollar. An increase in student and resident dues is not recommended.

2. It is recommended that $20,000 be budgeted for Board Contingency as reasonably anticipated expenditures. This is recognition of the fact that the Board has the authority to expend up to 10% of the value of unobligated assets of the Association (approximately $240,000) should unforeseen circumstances arise.

3. It is recommended that $75,000 be transferred from the Tort Reform Reserve to reduce expenses associated with tort reform activities. The allocation should be split between Administration salaries ($30,000) and Legislative & Bulletin Committee expenses ($45,000).

4. It is recommended that a balanced Fiscal Year 1991 Budget be submitted to the House of Delegates.

5. It is recommended that the capital budget request for a Personal Computer-Local Area Network (PC-LAN) and related software in the amount of $120,935 (bid of $109,941 plus 10% for unforeseen costs) be approved.

HOUSE ACTION

Adopted Recommendation 1 as amended: "Additionally, that the word 'Regular' be deleted and that the word 'Annual' be used in lieu thereof."

Adopted the budget and Recommendations 2-5 with the special request as follows: "That the Impaired Physicians Program, in a 2-year time frame, develop means of external support for its continued operations from sources other than MAG.

In addition, that a report from the medical director of the Impaired Physicians Program be given to the next House of Delegates in April, 1991, reporting the progress of this endeavor. Also, that a detailed report of expenditures and the projected budget be given."

MEDICAL ASSOCIATION OF GEORGIA BUDGET SUMMARY

Category	Projected May 31, 1990	FY 1990 Budget	Proposed FY 1991 Budget
Revenue			
Dues Revenue	$2,023,746	$2,023,746	$2,341,259
Advertising Revenue	105,000	105,000	135,000
MAG Mutual Agreements	131,250	175,000	182,500
Scientific Assembly	42,015	42,500	42,500
Leadership Conference	19,130	20,000	19,000
Journal Subscriptions	6,920	3,500	6,000
AMA Refund	20,992	20,992	20,000
Data Processing	5,000	8,000	5,000
Interest Income	100,352	88,000	95,000
Rental Income	30,000	33,000	26,000
Miscellaneous Income	47,100	20,000	30,000
Total Revenue From Operations	$2,531,505	$2,539,738	$2,902,259
EXPENDITURE SUMMARY			
Administration	$1,363,904	$1,418,823	$1,632,159
Membership Services	177,386	176,500	201,000
Building	177,482	180,500	193,840
Journal	176,465	174,200	189,200
Data Processing	72,696	88,600	77,100
Other	6,908	6,400	7,800
Board Contingent	20,000	20,000	20,000
Committees	536,501	474,715	581,160
Expenditures Regular Operations	$2,531,342	$2,539,738	$2,902,259
Revenue Over Expense Regular Operations	$163	$0	$0
Funded from Reserves:			
Director—Impaired Physicians	$26,667		

Category	Projected May 31, 1990	FY 1990 Budget	Proposed FY 1991 Budget
ADMINISTRATION			
Salaries	$872,274	$933,767	$1,066,218
Health Insurance	64,130	69,461	101,447
Disability Insurance	3,427	3,851	4,439
FICA Tax	61,966	60,734	69,494
Unemployment-State	591	2,091	139
Unemployment-Federal	1,444	1,358	1,526
Retirement	48,620	67,261	78,896
Recruitment	7,825	800	1,000
Legal Fees	25,000	15,000	25,000
Telephone & Telephone Equip.	42,163	52,000	45,000
Postage	40,000	45,000	45,000
Staff Travel	50,000	45,000	50,000
Printing	9,200	7,000	10,000
Dues & Subscriptions	16,500	9,000	17,000
Audit, Tax & Payroll	31,500	30,000	30,000
Equip. Maintenance & Xerox	13,587	12,000	13,500
Pension Administration	2,500	2,500	2,500
Consulting & Temporary Help	36,000	30,000	31,000
Office Supplies & Other	31,500	24,000	30,000
Insurance	5,677	8,000	10,000
Total Administration	$1,363,904	$1,418,823	$1,632,159

MEDICAL ASSOCIATION OF GEORGIA BUDGET SUMMARY

Category	Projected May 31, 1990	FY 1990 Budget	Proposed FY 1991 Budget
BUILDING			
Building Maintenance	$23,874	$18,500	$25,000
Janitorial Service	17,721	18,000	19,000
Insurance	2,500	7,000	8,000
Utilities	41,242	38,000	42,840
Depreciation-Building	32,000	32,000	32,000
Depreciation-Equipment	30,000	32,000	32,000
Ad Valorem Tax	30,145	35,000	35,000
Total Building	$177,482	$180,500	$193,840
MEMBERSHIP			
Travel—President	$20,580	$15,000	$18,000
Travel—President Elect	7,500	6,000	6,000
Travel—Past President	12,000	6,000	6,000
Travel—AMA Delegates	43,366	47,000	46,000
Caucus Expenses	13,556	9,500	14,000
Travel—Sec. & Treas. to AMA	2,341	3,500	3,500
Executive Committee Provisional	587	7,500	7,500
Executive Committee Travel	12,500	7,000	15,000
Meetings	9,500	15,000	15,000
President Provisional Fund	24,000	24,000	24,000
President Executive Fund	9,444	14,000	14,000
Roster	22,012	22,000	32,000
Total Membership	$177,386	$176,500	$201,000
JOURNAL			
Printing	$128,817	$135,000	$145,000
Photo Processing	1,500	1,500	1,500
Advertising Promotion	2,000	2,000	2,500
Postage	18,028	16,000	19,000
Clipping Service	353	300	300
Dues & Subscriptions	437	400	400
Consulting Services	10,707	10,000	10,000
Artwork	6,500	6,000	6,800
Travel	2,500	2,500	2,700
Office Operations	2,265		1,000
Bad Debt Expense	3,358		
Total *JOURNAL*	$176,465	$174,200	$189,200
OTHER			
Franklin/Woody Benefits	$6,908	$6,400	$7,800
Board Contingent	20,0000	20,000	20,000
Total Other	$26,908	$26,400	$27,800

MEDICAL ASSOCIATION OF GEORGIA BUDGET SUMMARY

Category	Projected May 31, 1990	FY 1990 Budget	Proposed FY 1991 Budget
DATA PROCESSING			
Insurance	$285	$800	$800
Equipment Rental	0	1,500	0
Equipment Maintenance	22,228	26,000	12,000
Data Communication	266	500	500
Supplies	5,474	8,500	6,000
Depreciation/Amortization	35,793	40,000	46,000
Travel	50	1,500	2,000
Education & Dues	178	300	300
Consulting Fees	4,000	4,000	5,000
Office Operations	4,422	5,500	4,500
Total Data Processing	$72,696	$88,600	$77,100

Category	Projected May 31, 1990	FY 1990 Budget	Proposed FY 1991 Budget
COMMITTEES			
Access to Health Care	$2,162	$2,100	$2,200
Annual Session	60,000	38,000	50,000
Auxiliary	35,000	35,000	44,310
Aux. Teen Health and OPSAL Forums	10,000	10,000	15,000
Continuing Medical Education	3,109	2,825	3,650
Doctor-of-Day	9,735	8,500	10,000
Hospital Medical Staff Section	2,500	5,000	10,000
Impaired Physicians	6,150	6,150	57,400
Leadership Conference	19,066	15,000	19,000
Legislation & Bulletin	135,000	125,000	115,000
Long Range Planning			7,000
Medical Aspects of Sports	1,214	1,500	2,200
Medical Practice	1,200	1,200	500
Medical Schools	816	1,000	1,000
Medical Student Section	16,070	16,070	13,000
Membership	25,000	4,000	10,000
Newsletter	41,142	26,400	45,000
Physician Involvement Program	4,018	2,700	3,500
Physician-Lawyer Liaison	0	4,000	0
Public Health	902	3,000	1,000
Public Relations	110,000	115,000	108,670
Resident Physician Section	6,030	6,030	5,030
Scientific Assembly	33,647	35,000	35,000
Third Party Relations	5,000	2,500	15,000
Young Physician Section	8,740	8,740	7,700
Total Committees	$536,501	$474,715	$581,160

REPORT OF THE IMMEDIATE PAST PRESIDENT

Joseph P. Bailey, Jr., M.D.

Refer to the Report of Reference Committee C for the complete text of the Immediate Past President's report.

Recommendations

1. That legislation be pursued which would protect the ability of physicians to control medical judgment and decisions about their patients. This recommendation extends to both the issues of Medicare and Medicaid. It should also be implicit that the issues deemed unalterable by legislative change be evaluated as to other avenues of definitive approach. These issues are coupled with the absolute need by adequate compensation for the practice of medicine in Georgia. *(Referred to Reference Committee C.)*

2. That MAG evaluate the need for expanded staffing and appropriate monetary, other benefits and recognition of our staff now present.

HOUSE ACTION

Adopted the second Recommendation with commendation.

REPORT OF THE CHAIRMAN OF THE BOARD

Thomas J. Anderson, Jr., M.D.

"These are the times that try men's souls." Thomas Paine said these words in 1776, but they are very appropriate for the last year of our dealing with AEtna, HealthCare COMPARE, and Health Care Financing Administration. There are those who say this has been a time of inflammatory and inappropriate letters to patients and physicians, and measurement by obscure and unrealistic protocols. Few medical offices have escaped unrealistic or totally inappropriate downgrading or denial of histories, physicals, consultations, and procedures. Appeals have not been answered for up to nine months when forty-five days is the limit set by HCFA. Many physicians have had to borrow money to meet their payrolls because of these denials and delays.

I have served on the Medical Advisory Committee to AEtna Medicare at the request of the Executive Committee and the President, and have attended five of these meetings in Savannah, three in Atlanta, and one in Augusta. Joe Bailey and I, with the good help of Paul Shanor and Cam Taylor, have presented the complaints, desires and suggestions of the Medical Association of Georgia to what has usually been an impassive and unbending group of people. An adversarial attitude usually pervades during these meetings.

It is my personal opinion that HealthCare COMPARE is determined to break the backs of the Georgia physicians with experimental review policies, and I feel that Georgia patients would be better off without those experimental policies.

Valuable help has been provided to the Medical Association of Georgia by the American College of Physicians and the American Society of Internal Medicine.

These meetings of the Advisory Committee to Medicare do provide the only dialogue between the parties and it is extremely important that they be continued. I recommend that travel and per diem for the physicians representing the Medical Association of Georgia continue to be paid in the customary manner.

I wish to express my appreciation to the Whitfield-Murray Medical Society and the Dougherty County Medical Society for hosting the June and January meetings and to Dan Stephens for his help as Vice Chairman of the Board.

Recommendations

1. That MAG continue its involvement in the Medical Advisory Committee to AEtna Medicare.

2. That the Medical Association of Georgia continue to pay the travel, accommodations and related expenses of physicians representing the MAG in our Medicare activities.

HOUSE ACTION

Adopted both Recommendations.

PUBLIC HEALTH COMMITTEE

O. Grey Rawls, M.D., Chairman

Refer to the Report of Reference Committee B for the complete text of the Public Health Committee report.

Recommendations

1. That the Public Health Committee continue its scrutiny of new federal and/or state laws and regulations concerning biomedical waste to insure that such protective measures are commensurate with research findings and that they are clearly communicated to physicians and their staff. *(Referred to Reference Committee B.)*

2. That the Public Health Committee assess the possible usefulness and/or appropriateness of an

Also serving on this Reference Committee were (L to R): William D. Logan, Jr., M.D., Medical Assn. of Atlanta; and Charles A. Lanford, M.D., Bibb.

updated and newly printed version of a Clinicians Guide to AIDS and HIV Infection in Georgia.

HOUSE ACTION

Adopted the second Recommendation.

PUBLIC RELATIONS COMMITTEE

Jeffrey T. Nugent, M.D., Chairman

(1) Health Care Rescue: Medicare

Medicare has stayed in the spotlight this year as problems with the carrier and its contractor have continued to mount. The Public Relations Committee, in response to the problems, has developed a public relations campaign aimed at educating the entire state regarding the problems we face as budget cuts continue. The committee worked closely with the Senior Citizens Advocacy Committee on the Physicians Care Program, which is still under study. However, the major thrust of the committee's actions has been aimed at the threats to patients and physicians by the decreasing funding of the Medicare program and increasing regulations.

The public awareness program has included key points of:

- a program to inform patients of their rights under Medicare,
- education of patients as to what the funding cutbacks and bureaucratic tangles mean to them, and
- suggested solutions.

The Public Relations Committee worked for several months to develop a brochure that would meet the key points without driving away the patients we want to reach. In this, we were greatly assisted by Dorothy Cohen, wife of our committee members Sheldon Cohen, M.D. Mrs. Cohen helped disseminate the proposed materials to groups of elderly citizens and to those who work with elderly citizens. We were able to tighten the material into a cohesive package that has met with great success. Every practicing physician member received a packet of 40 brochures from a total of 320,000. Along with those brochures we included a fact sheet.

The fact sheet includes several key points our committee wanted to make but that we were advised would be either objectionable to the elderly if put in the brochure without explanation or would require explanation beyond the scope of a limited publication such as a brochure. Instead, we designed the fact sheet as an aid to the physician when he or she is talking with a patient. The fact sheet is an educational tool for the physician to enable him or her to speak to some of the concerns we have about Medicare.

A major factor in our campaign has been television message advertisements running throughout the state and advising the people that we have a common problem with Medicare. The two commercials have drawn a strong, positive response from the viewing public. They ran from March 15 to April 22, on Thursdays and Fridays in prime times, and on Saturdays and Sundays. Placement was on WSB-TV and WXIA-TV, both Atlanta stations with cable-reach across the state and with strong older viewing audiences. Each caller has been sent the brochure on Medicare. The brochures end with a call to action to contact U.S. Senators and Representatives to discuss changes in the Medicare program. In the first two weeks of the campaign, more than 4,000 requests for brochures were met. We view our first media campaign a success.

Public Relations has been intensively involved in working with the news media this year in an effort to educate the public and key public leaders about the problems we in Georgia have been having with Medicare. The television reports have been uniformly favorable. Channel 11, which is seen throughout the state over cable stations, has run four stories on the issue. Channel 5 has run one story, which also ran in various cable markets statewide. The print media has been somewhat more difficult to convince. During a survey of MAG members last summer, at the request of the MAG Public Relations Committee, members were asked to give names of patients who were having particular difficulty with Medicare.

After *20/20,* a national television program, expressed interest to MAG in the AEtna carrier in Georgia, the Atlanta newspapers picked up on the story. The newspaper stories and editorials were distinctly anti-physician until the reporter began calling the patients whose names and numbers we supplied, and the story moved from the business pages to the front page. Immediately after that, in one 48-hour period, the newspaper received more than 3,000 phone calls from patients who have had problems with AEtna Medicare. The patients turned the attitudes at the newspaper around on this one issue. We also assisted *The Wall Street Journal, AM News,* and various other national publications with stories. We are now working with Public Broadcast's *MacNeil/Lehrer NewsHour* on a story on national health care problems for the elderly.

Public Relations also assisted with the Waxman Congressional Hearings in Atlanta last month (March 5), working with the press to help with favorable coverage of the problems experienced by patients and physicians.

(2) Tort Reform

Due to the efforts of the Public Relations Committee, the MAG Board of Directors designated $100,000 for a Obstetricial Tort Reform Campaign. Public Relations developed a fact sheet, summary of legislation, position paper and press kit, which were disseminated to media throughout the state. Editorial boards were visited at *The Atlanta Journal* and *The Atlanta Constitution, The Augusta Chronicle/Herald, The Albany Herald, The Columbus Ledger-Inquirer, The Macon Telegraph/News, The Marietta Daily Journal, The Gwinnett Daily News,* as well as several television stations. In Atlanta, Channel 5 and Channel 46 interviewed staff on the obstetrical crisis. We assisted in writing editorials for state newspapers for Joe L. Nettles, M.D., president of the MAG; Hugo Moreno, M.D., president of the Georgia Obstetrical and Gynecological Society; and Beverly Douglas, M.D., who met with several of the editorial boards around the state.

The Public Relations Committee plans to continue working on a statewide educational campaign to let the public know about the obstetrical crisis in Georgia and how it can be solved. We propose a 5 to 6 minute videotape that can be distributed to each legislator in Georgia. We also propose development of a speaker's bureau with training for those physicians who will talk to public leader groups across the state. We will need to develop new speeches, a slide show and new fact sheets and other materials as well as a new press kit.

(3) Other Activities of the Public Relations Committee

(A) Public Relations worked with MAG Membership in developing a new packet of materials to send to prospective members. The materials include three brochures, one explaining what MAG is, one directed at Students and a third directed at Young Physicians. The packets consisted of a tri-pocket folder, with MAG using one pocket, MAG Mutual using a second, and the county medical society using a third. Already they have received statewide awards. Among physicians, the packets have been well received, and membership is now at an all-time high of 7,225 up from 6,800 when the campaign started.

(B) Public Relations redesigned the MAG Newsletter to a more modern and readable format.

(C) In conjunction with the Long Range Planning Committee, Public Relations developed a survey to determine how physicians want MAG to operate in the future and what they consider MAG's most important missions. The results of this survey have been given to the Executive Committee for its use in planning the future direction of the Association.

(D) Public Relations took a more aggressive role in the Legislative efforts in the 1990 General Assembly. Public Relations worked closely with the Legislative Staff on projects including the tort reform legislation. Staff edited the *Legislative Bulletin* for the first time this year.

(E) Public Relations continued to distribute four patient brochures on *fitness, addiction, driving safety* and *stress.* The brochures were developed in 1988 as part of the Healthy Lifestyles Campaign.

(F) Public Relations distributed copies of the videotape on the *"It's Up to Youth"* program from 1989. Numerous requests for copies of this videotape were made, primarily from school and youth counselors. We look

forward to continuing this excellent program. Public Relations also wrote the nomination of the Auxiliary for an AMA Adolescent Health Award, winners of which will be announced in May.

(G) Public Relations assisted in drafting and in calling other states for results of the (Congressman Roy) Rowland Survey on how states allow physicians covering for other physicians to bill. Federal legislation has been introduced in part from information gathered from this survey.

(H) Public Relations assisted the MAG Auxiliary with its Crawford W. Long Stamp reissuance project. We also worked with the Southern Medical Auxiliary, whose president was a Georgian, Mrs. Barbara Thibodeaux, with the dedication of a plaque in memory of Mrs. Charles Almond, the Winder woman who established Doctor's Day.

(I) The Committee and staff continue to field a growing number of calls from print, television and radio media on a variety of topics on health care. We also continue to answer the requests of the public and physicians for information.

(J) Public Relations developed a physicians' brochure on battered women.

Recommendations

1. That the major public relations project for 1990-1991 be Medicare public education.

2. That MAG recognize the vast amount of misinformation about the profession that is accepted as fact and begin a program to counter that with the truth: that Georgians are fortunate in their outstanding physician community. We recommend a Physician Promotion Campaign that includes television advertising, a Workshop for the Media to talk about issues, and Business Outreach with leaders of our physician community and the state's business community.

3. We recommend that MAG continue distributing the excellent Healthy LifeStyles materials.

4. That MAG work with the AMA leadership in promoting the concept of insuring all employees through employee-based insurance and improve and extend government public programs for the truly needy.

5. That MAG continue to develop and carry out a statewide educational campaign to let the public know about the obstetrical crisis in Georgia and how it can be solved.

The Public Relations Committee met three times in 1989-1990, and the Chairman wishes to thank the members who gave a great deal of their time and energy to our projects:

John S. Antalis, M.D.; John Bostwick, III, M.D.; Sheldon B. Cohen, M.D.; William L. Dobes, Jr., M.D.; Kathy Easterling, M.D.; James G. Killebrew, Jr., M.D.; Peter L. Henderson, Jr., M.D.; Thomas A. Lyons, M.D.; Charles W. McDowell, Jr., M.D.; Toby S. Morgan, M.D.; Alan Promerance, M.D.; Beverly B. Sanders, Jr., M.D.; Nathan Segall, M.D.; Gerald Stapleton, M.D.; Joseph W. Stubbs, M.D.; Mrs. Charles W. Walden, (Grace); William Weston, M.D.; Edgar Woody, M.D.

HOUSE ACTION

Adopted Recommendations 1, 3, 4, and 5.

Adopted Recommendation 2 as amended, "That MAG recognize the vast amount of misinformation about the profession that is being accepted as fact and begin a program to counter that with the truth: that Georgians are fortunate to have such an outstanding physician community. We recommend a Physician Promotion Campaign that includes television advertising, a workshop for the Media to talk about issues, and Business Outreach with leaders of our physician community and the state's business community."

RESOLUTION 30

Alcohol Abuse Education in Elementary Schools

Alfred L. Davis, Jr., M.D.

Refer to Reference Committee D for the complete text of this Resolution.

RESOLVED, that MAG should prepare and distribute preventative and referral information on youth alcohol abuse for dissemination by physicians in office practices and public health clinics; and be it further

RESOLVED, that MAG should collaborate with the State Board of Education to see that appropriate anti-drug curricula are made more available in local elementary school systems. *(Referred to Reference Committee D.)*

HOUSE ACTION

Referred first RESOLVED to MAG Council on Public Relations.

RESOLUTION 48

Membership Dues Collection

Bob G. Lanier, M.D.

Whereas, presently there exist differences between MAG and its component county medical socie-

ties as to the date upon which membership dues are considered delinquent; and

Whereas, various component county medical societies, in receiving MAG membership dues, may at times withhold those dues for an unreasonably lengthy time before remitting said dues to MAG, thus resulting in the generation of delinquent dues notices from the AMA, GaMPAC and MAG; and

Whereas, the MAG Board of Directors has previously recognized this delayed remission of dues as a significant financial handicap for our Association, and has thus recommended to the House of Delegates that "county medical societies not remitting dues to MAG within 30 days of receipt will be subject to an interest penalty based upon the three month Treasury Bill Rate plus 3%"; now, therefore be it

RESOLVED, that the dues delinquency date for the Medical Association of Georgia and its component county medical societies be recognized uniformly as April 1; and, be it further

RESOLVED, that 30 days is a reasonable period for remission of dues; therefore any funds collected by MAG on behalf of its component county or district societies will be remitted within 30 days to the respective societies; and any funds collected by county or district societies on behalf of MAG will be remitted within 30 days to MAG.

HOUSE ACTION

Did not adopt.

RESOLUTION 49

Membership Dues for Young Physicians

Crawford W. Long Medical Society

Whereas, the future well-being of MAG depends on our strong membership recruitment of young physicians (those under age 40 or within their first five years of practice); and

Whereas, physicians entering the first several years of practice are encumbered both by considerable educational debt and the sizable costs of entering practice; and

Whereas, the MAG's present dues structure for new members offers a 2/3 reduction of full dues to physicians in their first year of practice, 1/3 reduction in their second year, and full-dues in their third; and

Whereas, this membership fee policy, while sympathetic to the problems of young physicians, is nevertheless perceived by some of them as still too costly, and therefore creates a barrier to membership in the Medical Association of Georgia; now, therefore be it

RESOLVED, that the MAG Committee on Membership Expansion and Involvement and the MAG Committee on Finance collaborate to study our Association's dues policies for physicians entering practice to develop proposals offering further inducements for those physicians to join MAG; and to bring those proposals to the next House of Delegates for discussion and possible implementation.

HOUSE ACTION

Referred to Membership Expansion and Involvement Committee.

RESOLUTION 57

Public Awareness Campaign Concerning Threats to Medical Practice

Bibb County Medical Society

Whereas, Medicare and its bureaucracy and its seemingly arbitrary standards are driving a wedge in the doctor/patient relationship; and

Whereas, the legal climate which had led to defensive medicine has needlessly increased the cost and anxiety in the practice of medicine; and

Whereas, fiscal restraints by governmental agencies will eventually lead to rationing of medical care; and

Whereas, all these factors have led to a decrease in satisfaction in the practice of medicine by physicians, which is reflected by a decrease in the quality and the number of applicants to medical school; and

Whereas, if these trends continue, there will be a significant decrease in the quality of medical care delivered to the citizens of Georgia; now, therefore be it

RESOLVED, that the MAG Public Relations Council study the public relations program developed by the Physicians for Canada in Vancouver, B.C., which focuses on similar problems; and be it further

RESOLVED, that the MAG Public Relations Council, should it find that this program is adaptable for MAG's purposes, develop and have ready by September 1990 a program applicable for radio and television broadcast to focus public awareness on these problems in the State of Georgia.

HOUSE ACTION

Adopted.

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- *Heals duodenal ulcer rapidly and effectively[4,5]*
- *Dosage for adults with active duodenal ulcer is 300 mg once nightly (150 mg b.i.d. is also available)*

References
1. *USP DI Update, September/October 1988, p 120.*
2. *Br J Clin Pharmacol 1985;20:710-713.*
3. *Data on file, Lilly Research Laboratories.*
4. *Scand J Gastroenterol 1987;22(suppl 136):61-70.*
5. *Am J Gastroenterol 1989;84:769-774.*

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Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Report of Reference Committee C&B

The Reference Committee on Constitution and Bylaws was comprised of the following physicians: Joy A. Maxey, Chairman, Dekalb; Cecil L. Miller, Vice-Chairman, Gwinnett-Forsyth; William C. Acton, Bibb; Hugh S. Thompson, Jr., Medical Association of Atlanta; Ellis B. Keener, Hall; Edmund (Mac) Molnar, Muscogee; James F. Beattie, Jr., Walker-Catoosa-Dade; and Kenneth L. Goldman, Muscogee. MAG Staff, Lynn Pearson, Director of Membership.

COMMITTEE ON CONSTITUTION AND BYLAWS

J. Rhodes Haverty, M.D., Chairman

The Committee on Constitution and Bylaws met to consider several matters previously referred to it and submits the following report for consideration by the House of Delegates. *(Note: Amendments by addition are underlined and amendments by deletion are ~~crossed out.~~)*

CONSTITUTIONAL AMENDMENTS

1. The following Constitutional amendments proposing changes to Article V, Section 1, and Article VI, Section 1 were introduced as Resolution 28 at the 1989 session of the House of Delegates. These amendments have lain on the table for one year and have been printed in the MAG *Journal* as required. They are presented here for a vote by the House of Delegates.

The 1989 House adopted amendments to Chapter IV, Section 5; Chapter V, Section 1 and Section 5; Chapter VII, Section 5 of the Bylaws which removed the Executive Director from being a member of certain groups. The purposed Constitutional amendments are in furtherance of the acts of the 1989 House of Delegates.

(a) If adopted as presented, Article V, Section 1 would remove the Executive Director as an ex-officio, non-voting member of the House of Delegates.

(Note: Admendments by addition are underlined and amendments by deletion are ~~crossed out.~~)

Article V —
House of Delegates

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component societies, the Resident Physician Section, the Young Physician Section, the Medical School Section, and the Hospital Medical Staff Section. All delegates' qualifications and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, ~~the Executive~~

~~Director~~ and Chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

(b) If adopted as presented, Article VI, Section 1 would remove the Executive Director as an ex-officio, non-voting member of the Board of

Article VI — Board of Directors

SECTION 1. COMPOSITION. The Board of Directors is composed of the President, the President-Elect, the Immediate Past President, the two preceding immediate past presidents, two vice presidents, Secretary, Treasurer, Speaker of the House of Delegates and Directors as provided for in the Bylaws. Delegates and Alternate Delegates to the AMA, Editor of the *Journal*, past presidents other than the three immediate past presidents ~~and the Executive Director~~ shall be ex-officio members of the Board of Directors without the right to vote. Alternate Directors shall be ex-officio members except in the absence of their respective Directors as provided for in the Bylaws. The Vice Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

2. The following Constitutional amendment was introduced as Resolution 44 at the 1989 session of the House of Delegates. It also has lain on the table for one year, has been printed in the MAG *Journal* and is presented here for a vote by the House of Delegates.

If adopted, Article IV, Section 1 would authorize an "At-large" membership category that would exempt from unified membership certain members who would be identified in a subsequent Bylaws amendment.

HOUSE ACTION

Adopted.

Article IV — Membership

SECTION 1. MEMBERS. The members of the Association are the members of the component county medical societies except as exempted by the Bylaws. The Association is composed of Active, Service, Associate, At-large and Honorary members as provided for in the Bylaws. Other types of membership may be provided for in the Bylaws.

The standing Committee on Constitution and Bylaws recommends against adoption of this Constitutional amendment. If, however, the House of Delegates, in its wisdom, elects to adopt it, the following Bylaws amendment should also be adopted in order to implement what the Constitutional amendment authorizes.

Chapter II — Membership

SECTION 1. ACTIVE MEMBERS.

(iv) A physician shall hold the degree of Doctor of Medicine, Doctor of Osteopathy or Bachelor of Medicine or an equivalent degree issued by a foreign country from a medical college acceptable to the Judicial Council of the Association, be licensed to practice medicine in the State of Georgia, and have his/her dominant practice in a country that is not affiliated with a properly chartered component county society. The Judicial Council shall review and approve or disapprove each At-large application to determine if all the within stated requirements are met, including a determination as to the validity of the charter of a component county society. A member under this subsection shall be designated as a member At-large and shall not be required to join a component county medical society as is required elsewhere in these Bylaws.

HOUSE ACTION

Not adopted.

Joy A. Maxey, M.D., Atlanta, Chairman of the Reference Committee on Constitution and Bylaws.

RESOLUTION 3

Qualifications for Life Membership

William G. Whitaker, III, M.D.
Charles W. McDowell, M.D.
Roy W. Vandiver, M.D.
R. H. Almeroth, Jr., M.D.
Walker L. Ray, M.D.

This Resolution is identical to Resolution 29 introduced at last year's (1989) House of Delegates meeting. On that occasion it was voted down by the House on the recommendation of the Reference Committee that it not be adopted.

The purpose of this Resolution is to lower from age 70 to age 65 the age at which a member may qualify as a Life member. Life members are exempt from dues and assessments.

Serving on the Reference Committee on Constitution and Bylaws were (L to R). James F. Beattie, Jr., M.D., Walker-Catoosa-Dade; Kenneth L. Goldman, M.D., Muscogee; and Cecil L. Miller, M.D., DeKalb, Vice-Chairman.

(Note: Amendments by addition are underlined and amendments by deletion are ~~crossed out.~~)

Whereas, most national specialty organizations place a physician into a dues-exempt membership category upon reaching the age of 65; and

Whereas, the current Bylaws provide life membership after a physician has been continuously an active, dues-paying member for 25 years and reached the age of 70; now, therefore be it

RESOLVED, that Chapter II, Section 7 of the Bylaws be amended by deleting the number "70" and inserting in its place the number "65" so that when amended it will read:

"Chapter II. Membership
Section 7. Life Members.

A member in good standing who is ~~70~~ 65 years of age (on or by January 1 of the current dues year) may be classified as a Life Member and excused from the payment of Association dues and assessments upon application to the Association through the appropriate component county society as follows: the physician's application shall be granted in due course if such member has been continuously an active dues-paying member of this Association for 25 years; the application shall be granted in due course if the physician has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years, provided that the physician has been an active dues-paying member of this Association for at least two of those 25 years; the application may be granted upon action of the Judicial Council if the physician has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continously for 25 years but has been an active dues-paying member of this Association for at least one year and less than ten years. . . ."

HOUSE ACTION

Not adopted.

RESOLUTION 6

MAG Committee on Scientific Assembly

Roland S. Summers, M.D.
Hillary R. Newland, M.D.
William E. Silver, M.D.
Carl L. Rosengart, M.D.
Rodney L. Smith, M.D.

The following Resolution is jointly sponsored by members of the Committee on Scientific Assembly and the Committee on Continuing Medical Education. It calls for a merger of the two committees and subsequent designation as a Special Committee (as distinct from a Standing Committee) to be known as the Committee on Scientific Assembly and Continuing Medical Education.

The Resolution was offered in response to a request from the Accreditation Council for Continuing Medical Education, the national accrediting authority, to "simplify the chain of command." It has been approved by the full committees on CME and Scientific Assembly.

The Constitution and Bylaws Committee has reviewed the Bylaws amendment contained in the Resolution and finds it suited to accomplish the stated objective.

(Note: Amendments by addition are underlined and amendments by deletion are ~~crossed out~~.)

(L) Edmund (Mac) Molnar, M.D., Muscogee; and Hugh S. Thompson, Jr., M.D., Medical Assn. of Atlanta, also served on this Reference Committee.

Whereas, the Medical Association of Georgia House of Delegates in 1973 approved the creation of a fall multi-specialty MAG scientific meeting to be held in Atlanta; and

Whereas, this MAG Scientific Assembly has been held annually since 1975, with continuing medical education programs planned by participating specialty societies; and

Whereas, a Committee on Scientific Assembly was created in 1975 to monitor these activities, and was made a Standing Committee of the Association by the House of Delegates in 1977; and

Whereas, the MAG Continuing Education (CME) Committee is authorized to grant American Medical Association Category 1 credit for the Scientific Assembly; and

Whereas, The Scientific Assembly Committee must submit all specialty CME programs to the MAG Continuing Medical Education Committee for approval and AMA Category 1 credit; and

Whereas, this procedure of two MAG Committees working on the same project has proven difficult and ineffective; and

Whereas, the national continuing medical education accrediting authority, ACCME (Accreditation Council for Continuing Medical Education), has called on MAG "to revise the composition of committees which deal with CME in order to simplify the "chain of command"; now therefore be it

RESOLVED, that the Scientific Assembly and Continuing Medical Education Committees shall be merged into a special committee of the Association, entitled "Committee on Continuing Medical Education and Scientific Assembly"; and be it further

RESOLVED, that Chapter X, Section 1 of the Bylaws be amended by deletion of line "(G) Committee on Scientific Assembly", and the substitution of "(G)" for "(H)", so that when amended the Section will read:

"SECTION 1. STANDING COMMITTEES. The standing committees of the Association shall be as follows:

(A) Executive Committee of the Board of Directors
(B) Committee on Finance
(C) Judicial Council
(D) Committee on Auxiliary
(E) Committee on Constitution and Bylaws
(F) Committee on Annual Session
~~(G) Committee on Scientific Assembly~~
~~(H) Committee on Publications~~
(G) Committee on Publications

and be it further

RESOLVED, that Chapter X, Section 8, "COMMITTEE ON SCIENTIFIC ASSEMBLY" be deleted and that Section 9 be renumbered as "SECTION 8. ~~COMMITTEE ON PUBLICATIONS~~," so that when amended the Section will read

SECTION 8. — COMMITTEE ON SCIENTIFIC ASSEMBLY

(a) PURPOSE. ~~The Committee shall conduct such general scientific meetings as it considers beneficial to the membership of the Medical Association of Georgia and the medical profession as a whole in the State of Georgia, consistent with the affirmed policies of the Association as directed by the Board of Directors and the House of Delegates.~~

~~(b)~~ COMPOSITION. ~~The Committee shall consist of a Chairperson appointed annually by the Executive Committee, and by reason of their offices, the current Chairperson of the Committee on Specialty Society Relations and the Chairpersons of the other committees in the Council on Education.~~

~~**SECTION 9. — COMMITTEE ON PUBLICATIONS.**~~

SECTION 8. COMMITTEE ON PUBLICATIONS. The Executive Committee shall serve as the Committee on Publications. It shall oversee the publication of *The Journal of the Medical Association of Georgia.*

HOUSE ACTION

Adopted as amended: "That the Committee on Scientific Assembly and the Committee on Continuing Medical Education be merged as a special committee, named "Committee on Continuing Medical Education," with the combined charges of the Committee on Scientific Assembly and the Committee on Continuing Medical Education."

COMMITTEE ON CONSTITUTION AND BYLAWS

J. Rhodes Haverty, M.D., Chairman

The MAG Executive Committee of the Board of Directors requested the Constitution and Bylaws Committee to draft and present to the House of Delegates all the amendments necessary to delete Councils from the Bylaws. The Executive Committee wishes to retain Council status for the Judicial Council, the Council on Public Relations and the Council on Legislation.

As was pointed out in the Executive Committee request, the Council system structure has not worked well since being adopted six years ago. In an effort to improve the operating efficiency of the various committees and their reporting system, the Executive Committee has requested that the Councils be deleted from the Bylaws.

To accomplish the above objectives:

1. Add the Council on Public Relations and the Council on Legislation to the list of standing Committees in Chapter X, Section 1;
2. Amend Chapter X, Section 6, CONSTITUTION AND BYLAWS, by deletion of the words: "the Council on Administration and",
3. Add a new Section 10, COUNCIL ON LEGISLATION and a new Section 11, COUNCIL ON PUBLIC RELATIONS to Chapter X; and
4. Repeal Chapter XII in its entirety and re-number all succeeding chapters accordingly.

When so amended, Chapter X, Sections 1, 6, 10 and 11 would read as follows:

(Note: Amendments by addition are underlined and amendments by deletion are ~~crossed out~~.)

Chapter X — Committees

SECTION 1. STANDING COMMITTEES. The standing committees of the Association shall be as follows:

(A) Executive Committee of the Board of Directors
(B) Committee on Finance
(C) Judicial Council
(D) Committee on Auxiliary
(E) Committee on Constitution and Bylaws
(F) Committee on Annual Session
~~(G) Committee on Scientific Assembly~~
~~(H) Committee on Publications~~
(G) Committee on Publications
(H) Council on Legislation
(I) Council on Public Relations

SECTION 6. CONSTITUTION AND BYLAWS. The Committee on Constitution and Bylaws shall be responsible for the continuing study of the organization of the Medical Association of Georgia. It shall recommend to the House of Delegates,

through ~~the Council on Administration and~~ the Board of Directors, any amendments or revisions which seem necessary or advisable. At least every five years the Committee on Constitution and Bylaws shall recommend revisions after a complete study of the organization of the Association and its Constitution and Bylaws. Proposed amendments shall be referred to the Committee on Constitution and Bylaws for recommendation before action thereon is taken by the House of Delegates.

SECTION 10. COUNCIL ON LEGISLATION. The Council on Legislation shall continually review pending legislation, active bills, the need for particular legislation, recommend positions of policy to policymaking bodies of MAG and communicate the Medical Association of Georgia's position to the Georgia Congressional delegation and to State legislators.

SECTION 11. COUNCIL ON PUBLIC RELATIONS. The Council on Public Relations shall provide advice and assistance, upon request, to the Medical Association of Georgia committees, the Board of Directors, and the House of Delegates in communicating the Association's positions and policies to the public.

The Council shall make recommendations as to the annual budget of the Association that will serve the best interest of the Association in relating to the public and shall serve as the oversight committee for the Public Relations Department.

~~CHAPTER XII — COUNCILS AND THE PRESIDENT'S CABINET~~

SECTION 1. ~~ORGANIZATION AND RESPONSIBILITIES OF COUNCILS. All standing and special committees of the Association shall be grouped by the Executive Committee into eight functional areas and each group shall be overseen by a Council. Each of the Councils shall be composed of the Chairman of its several committees and shall be chaired by another Association member appointed by the Executive Committee.~~

~~Each Council shall coordinate and supervise the activities of the several committees under its jurisdiction. Each Council shall meet at least semiannually, the first meeting being as soon as practical after the Annual Session for planning, and the second meeting prior to the following Annual session for the purpose of receiving and acting upon committee recommendations.~~

SECTION 2. ~~PRESIDENT'S CABINET. The eight Council Chairmen shall be designated as the President's Cabinet to meet semi-annually with the MAG President presiding, for the purpose of considering the current and future activities of the Association and assigning tasks and projects to the several Councils and committees.~~

CHAPTER XIII — EXECUTIVE DIRECTOR. Re-number as CHAPTER XII.

CHAPTER XIV — THE JOURNAL. Re-number as CHAPTER XIII.

CHAPTER XV — RULES AND ETHICS. Re-number as CHAPTER XIV.

CHAPTER XVI — AMENDMENTS. Re-number as CHAPTER XV.

CHAPTER XVII — REPEALER. Re-number as CHAPTER XVI.

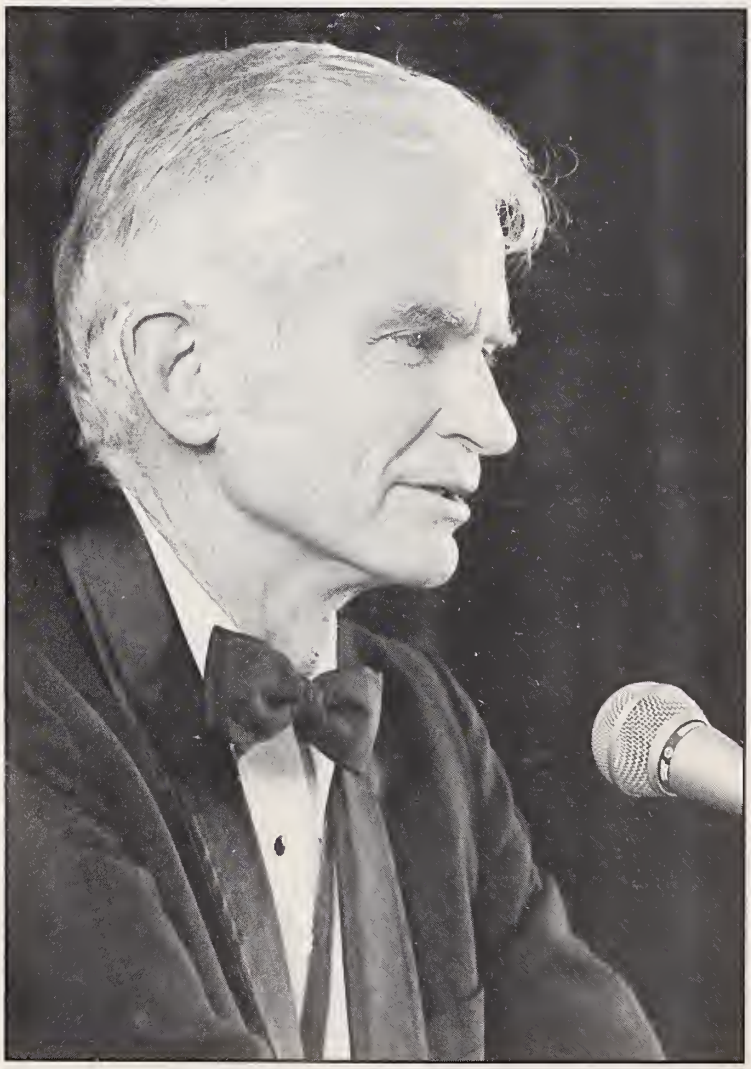
HOUSE ACTION

Adopted as amended, deleting reference to "Council" in Chapter XI, to conform to the other deletions of Councils through the Bylaws.

Final General Session

Installation Ceremony

Saturday, April 28



MAG President Joe Nettles addresses the audience at the Installation Ceremony Saturday night, highlighting some of the Association's activities and achievements during his year in office.

As SPEAKER of the MAG House of Delegates, Dr. Kaufmann welcomed those attending MAG's third Installation Ceremony. This ceremony was created to present the Presidents' addresses and the formal installation of officers in a joint ceremony, conveniently scheduled for all members, auxiliians, and guests to witness the transfer of leadership within the Association.

Joseph P. Bailey, Jr., M.D., gave the invocation. Sheila Greene sang "America the Beautiful."

Speaker Kaufmann introduced MAG's outgoing President, Joe L. Nettles, M.D., who has been an outstanding leader of the association in an extraordinary year of major issues. With the help of his wife, Sarah, Dr. Nettles set new standards for future leadership of the Association.

Outgoing Presidential Address

The events of the past year have been considerable in both scope and depth. We have faced many problems and still have many before us. As the old cliche goes, "There is good news and there is bad news." First the good news.

Due to both the many problems facing medicine at this time and the hard work of staff and the Membership Expansion and Involvement Committee, we have grown to a membership of 7267, which represents a net gain of 345 over the past year. I am delighted that MAG has over 75% of its members also as AMA members. This entitles us to another delegate and alternate delegate to the AMA!

Under guidance of our President-Elect, the Executive Committee met with leaders from specialty societies, and from local and district societies. Developing a long-range questionnaires were sent to all our membership regarding the mission, goals and shortcomings of our organization. We believe we are now in a better position to plan for the future.

The Issue of AEtna, HealthCare COMPARE: Medicare Part B has consumed the bulk of the energies of MAG staff and leadership, and well it should. No other issue has so affected the practice of all MAG members. The inefficiencies of AEtna and the designed interference of HealthCare COMPARE have made medical practice, especially by the primary specialties, so difficult that many physicians have been forced to modify their practice or terminate practice altogether. More than that, it is the patient who suffers most. Through the persistent efforts of MAG staff and physicians throughout the State, these inadequacies have been recognized, not only in this State, but throughout the nation. The recent convening of a Congressional Subcommittee hearing attests to the gravity of the problem. We still have a long way to go toward recognizing and achieving the solution.

"Two minutes to go, Dr. Collins." MAG's Executive Director Paul Shanor (L) goes over last minute preparations for MAG's formal Installation Ceremony when the Association's officers for 1990-91 are sworn in.

The major goal of this year's legislative effort was to obtain relief for the dwindling number of practicing obstetricians in this State. Although we had an impressive victory in the Senate, the Speaker burried the Arbitration Bill in the House. Although this was lost, we were successful in having formed a Governor's Blue Ribbon Obstetrical Crisis Commission to recommend solutions to the 1991 General Assembly. The remaining actions of the Session were favorable toward quality medical care, thanks to much effort from our Legislative Staff, our Auxiliary and many concerned physicians.

Probably the most satisfying achievement of the past year has been on the behalf of the Savannah obstetricians. The Justice Department, acting on the request of the Federal Trade Commission, has been investigating a complaint of alleged price-fixing on the part of all 31 Savannah obstetricians in a response to a business coalition inquiry over 5 years ago. A Federal Grand Jury was convened and met for over a year. This has put those thirty-one obstetricians through a living hell. MAG, with aid from AMA, employed the best legal experts on such matters, in cooperation with each physician's individual attorney, to prepare a joint defense to be used in event of an indictment being sought. We have now learned that the Grand Jury has been disbanded and that no criminal indictment will be sought.

Now for the bad news — we still face unresolved problems.

HCFA and Congress may feel that all of the complaints from the doctors of Georgia are an indication that AEtna and HealthCare COMPARE are doing a good job as far as cost saving measures are con-

cerned. We must continue to point out that the patients of Georgia are the real losers in this process.

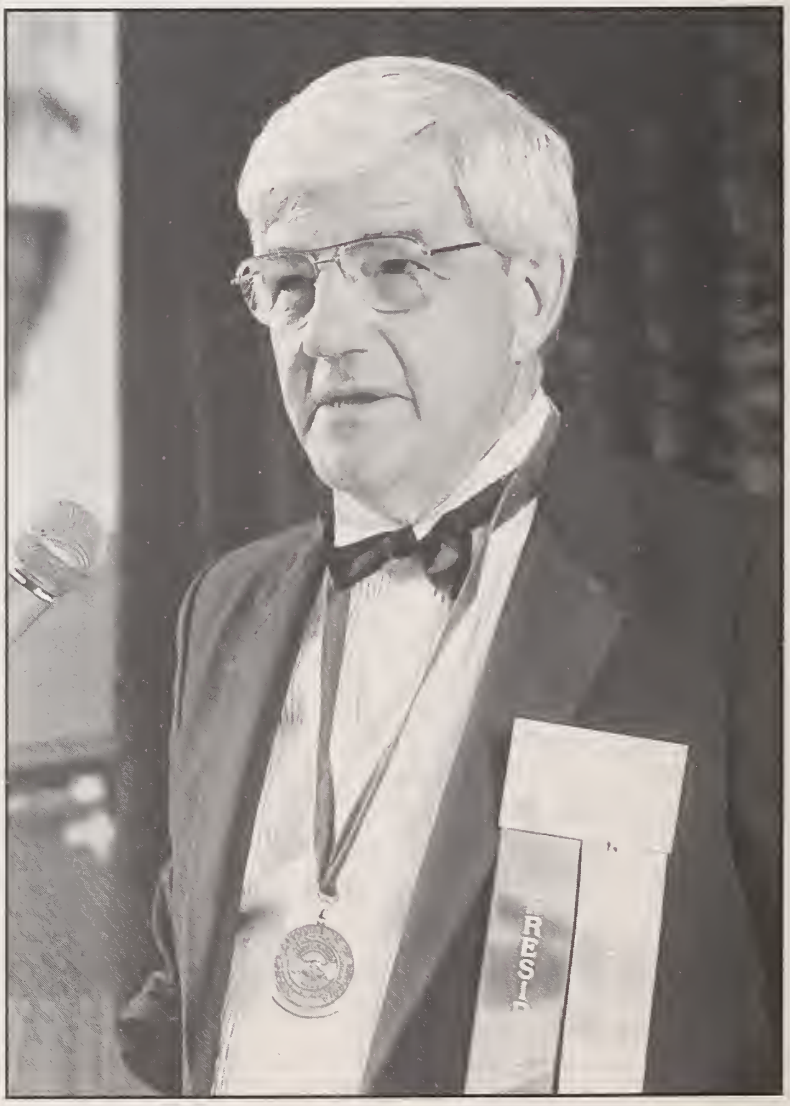
Our Physician Care Program is yet to be launched. Thus far we have been fortunate in staving off attempts in the past two legislative Sessions to mandate acceptance of assignment both for Medicare and Medicaid. However, if we do not push forward with an active program to demonstrate to the people of this State that they will always have access to good affordable health care, we will find ourselves in the deplorable position of Massachusetts and other such states where mandatory assignment has resulted in a wholesale exodus of physicians from the State. At this point, less than 15% of our membership have made a positive response to our survey soliciting their aid in the Physician Care Program. This is hardly a mandate with which to push forward. Yet, we have always taken care of our population's health needs and we must continue to do so.

No one denies that medical care in the United States is the best in the world, but it is also generally recognized as the most expensive. Because of expanding technology, an aging population, liability and other factors, Health Care consumes 12% of our Gross National Product and some people feel that this nation can no longer afford our services. Our national leaders are looking to other nations to see which model we can adopt that will be affordable yet take care of our citizen's health needs.

A few months ago in the middle of a busy office schedule I received a phone call from London. It was from my son, Lee, a 3rd year student in the University of Georgia School of Business, then participating in an exchange program with the University of London. After 6 weeks of didactic lectures he was serving an 8 week internship with a London advertising firm. "Dad, I want you to send me all the information you can on private Health care insurance in the United States to help me with a project. One of his advertising firm's chief clients was Summa, the largest private insurance carrier in England. It seems that Business executives and all who can afford it are now opting for private Health care. They are tired of the long lines and the inferior product of the National Health Services.

Last week at the annual meeting of the Medical Association of Alabama we heard the president of the Canadian Medical Association relate the growing frustration and disenchantment of Canadian physicians and citizens.

Yes, our system is expensive, and we must find ways to cut costs and make it affordable to all, but it is the best and we must keep it so. With the help of you all, through efforts such as we have just concluded in this house of Delegates we will prevail. Thank you for a wonderful year.



Dr. Bill Collins addresses the delegates and guests after being sworn in as MAG's 1990-91 President.

Installation of New Officers

As his last official duty as President of MAG, Dr. Nettles installed the new officers of MAG as follows:

President: William C. Collins, M.D., Atlanta; *President-Elect:* Cyler D. Garner, M.D., Gordon; *First Vice President:* Roy Vandiver, M.D., Lawrenceville; *Second Vice President* Alva L. Mayes, M.D., Macon; *Treasurer:* Bob Lanier, M.D., of Cumming:

Judicial Council: Carolyn Jean Williams, M.D., Savannah; and John Watson, M.D., of Columbus; *AMA Delegates:* S. William Clark, Jr., M.D., of Waycross; Joe C. Stubbs, M.D., of Valdosta; Carson B. Burgstiner, M.D., of Savannah; William Logan, M.D., of Atlanta;

AMA Alternate Delegates: Mac Molner, M.D. of Columbus; Ralph Tillman, M.D., of Norcross; Ellis B. Keener, M.D., of Gainesville; Joe L. Nettles, M.D. of Savannah; William C. Collins, M.D. of Atlanta;

Young Physicians AMA Delegate, Joy Maxey, M.D., of Atlanta; *Young Physicians AMA Alternate Delegate*, James Beattie, M.D., of Fort Oglethorpe.

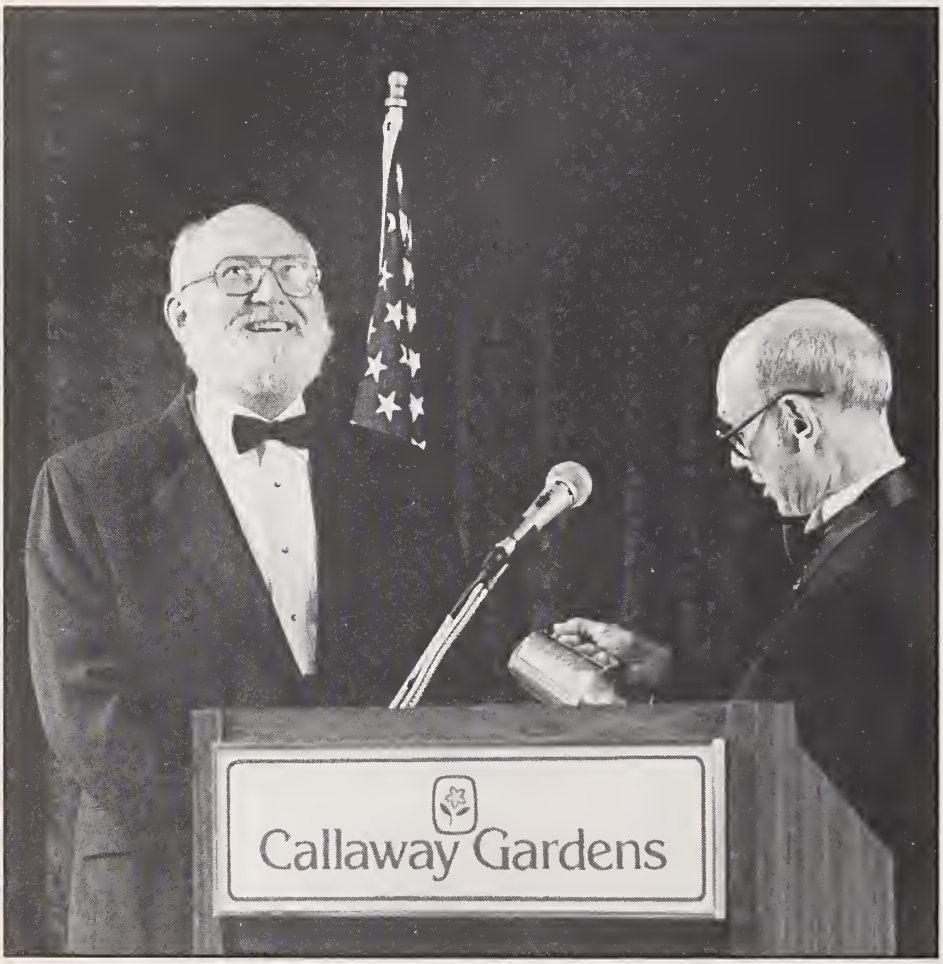
Dr. Nettles then introduced Dr. William C. Collins of Savannah as the new president of MAG, and presented him with a presidential medallion and a lapel pin.

Dr. Collins presented Dr. Nettles with the president's pin, a bound volume of the *Journal* containing his President's Pages published during his term, and a past president's medallion. Dr. Collins then addressed those assembled after which he adjourned the Installation Ceremony inviting all present to attend the President's Reception.

He's earned it and earned it well: Joe Nettles receives his Past President's medallion from MAG's new President, Dr. Bill Collins as a symbol of his year of strong service to the Association in 1989-90.

Incoming Presidential Address

Friends, family, fellow physicians and auxiliarians, it is my pleasure at this time to accept the honor and leadership of the Medical Association of Georgia for the coming year. Although I have been preparing myself for this job for the last twenty years of my life and at least for the last year, have known that the time would come when this mantle of responsibility would be passed on from Dr. Nettles to me and I would have to walk in the big footsteps of such men as Joe Nettles, Joe Bailey and the many other giants of medicine who have filled these shoes in the 141 years of our existence as an association. I can report to you during the past year and close observation of the staff at the Medical Association of Georgia that we are perhaps in the best shape that we have ever been from the standpoint of talent, energy, enthusiasm and dedication by a group of people to the well-being and health of the people and physicians of the State of Georgia. I am well aware of the many hours in the last several days that most of you have spent in dedicated negotiations and legislation of policy for the Medical Association of Georgia and I will not impose upon you to any great extent. I am torn between the advice of Abraham Lincoln who, at Gettysburg, probably shortened more speeches than anyone else in the history of mankind when he so aptly stated, "The world will little note nor long remember what we say here." On the other hand, the great historian Santana aptly reported that, "Those who do not know the mistakes of the past obligate themselves to repeat them." I would like, at this time, to at least vocalize a summary of my thoughts and plans for the Medical Association for the coming year for oftentimes, unless these are vocalized, very little action is accomplished. Those of you who remember the



Dr. Cyler Garner (L) is commended for his years of service as MAG's Treasurer, 1984-1990 by MAG Past President Joe Bailey. (The cup is inscribed to him as "Money Bags.") Dr. Garner assumed the office of President-Elect during the Saturday evening ceremony.

episode on the Andy Griffith show when Aunt Bea was offering herself for leadership in the county government, and quizzed repeatedly by her opponent concerning her plans in her role as a County Commissioner she, very naively but honestly, stated, "I will carry out the will of the people." While I can assure you that I will certainly strive to do this, I would like to offer at this time a somewhat more fleshed out program than Aunt Bea's philosophy. Of course, those of you in this room realize that when I use the word I, I am certainly meaning we — for one physician in this state can do little except act as a stimulus to the collective will.

In considering the role of medicine in the medical care system in this country, it is important for us to recognize the uniqueness of the relationship between the physicians in this country and their patients. It is unlike the relationship of these two entities anywhere else in the world and for anyone to suggest that a system could be lifted from another nation and brought to this country would place them in the role of being totally ignorant of the history of the development of our own medical care system. From a relatively weak traditional profession of minor economic significance, medicine has become a sprawling system of hospitals, clinics, health plans, insurance companies and myriad other organizations employing a vast labor force. It is a market story in that the transformation that we are suggesting has been propelled principally by the advance of science along with the satisfaction of human needs and in this country, particularly, human wants. Authority of the medical professional has principally been based upon the close bond with modern science and the privileged status given to scientific knowledge in the United States of America. I think it behooves all of us who are involved in shaping policy for the coming years and coming century in medicine to be particularly aware of the past and what has happened to bring our profession to the level where it is at this point in time. So often we have studied the scientific advances of medicine without understanding the history of the development of the "American system of medicine." I would lift up to you as a study vehicle the Pulitzer Prize winning book in 1984 by Paul Star entitled *A Social Transformation of American Medicine* in which he outlines quite well how the American system of medicine has developed causing it to go from the status of that described in 1832 by J. Marion Sims, who would later become one of America's foremost surgeons. He stated he returned home to his family in South Carolina after graduating from college, that he disappointed his father greatly by not becoming a clergyman or a lawyer. He thought the profession of medicine would make the fewest demands on his frail talents and he informed his father of such. "If I had known this," his father said in an outburst, "I certainly should not have sent you to college. It is a profession for which I have the utmost contempt. There is no science in it. There is no honor to be achieved in it and no reputation to be made." In the years from 1800 to 1850, in a survey of the 12,400

men graduated from eight leading colleges in the east, 26% became clergymen and a similar percentage became lawyers. Under 8% became physicians. Furthermore, the proportion going into medicine was lower among students who graduated with honors than among students in general. The figures were indicative of a general distaste for medicine among the "educated talent of the country." As late as 1870, a medical journal remarked that when a young man of merit and ability chose to become a doctor, the feelings among the majority of his cultivated friends is that he has thrown himself away. The fact that the status of the physician rose in the next one hundred years to the point where again and again physicians were listed at the top of the professional grouping is a tribute to the caliber of men who became physicians as well as to the peculiar relationship that Americans began to develop with their physicians to the extent that they considered good health to be one of their chief priorities and were supportive of advances in both public and private health.

Medical organizations in this time period reflected the status of the individual physicians and the first collective attempt at a national organization, the American Medical Association, was described early-on as a purely volunteer organization without any charter privileges and with no authority to enforce its own edicts. Increased professionalism was promoted by medical societies and associations from their inception, but it fell to the work of a young educator, Abraham Flexner who, at the request of the AMA and under the auspices of the Carnegie

One of the most surprising highlights at the Installation Ceremony were these kilted bagpipe players. Dr. Joe Bailey organized this surprise event unbeknownst to Dr. Collins. To the left of the photo are (L to R) Drs. Collins, Kaufmann, and Nettles.

Dr. and Mrs. Milton Johnson, from Macon, chat with friends. Dr. Johnson is a Past President of the MAG.

Foundation, developed a report which was published in 1910 urging the closing of many substandard medical schools and refinement of the curriculum and training of physicians which led to increased confidence of the people in medicine. The principle theme that one can gain from Mr. Star's book is that there have always been problems confronting medicine and the delivery of health care and for us to be overwhelmed by the seemingly unresolvable conflicts and attitudes of our day would be incompatible with the history of our profession and the challenges that have been met in the past. In the coming year, I would hope that we would be able to resolve to some degree, the tremendous problem presented to the Medicare patients and their physicians in this state by the Aetna Health Care Compare 198mplex that has been so notably carried on under the leadership of Dr. Bailey, Dr. Nettles and Dr. Tom Anderson. This is certainly a skirmish in the greater battle that we must conduct along with AMA in pushing for a total re-organization of the Medicare system so that it can do the job that it set out to do in an appropriate and fair manner.

We must continue to work with the Access to Health Care Committee, a blue ribbon committee appointed by the Governor and our group of physicians headed by Dr. Bob Lanier. In instituting as many of the sixteen points of action itemized by the AMA for resolving of this continuing problem for Georgia citizens. We must be justly proud of the stabilization of the continuing escalating premiums for malpractice insurance in our state we must not sit on our laurels, but must continue to work for the continued downward trend in the malpractice premiums and find ways to work with the Bar Association in helping many of our specialty groups get out from under the hostage situation that they are being held under created by a small group of aggressive and avaricious plaintiffs' Bar members.

We must look carefully at the Medical Association of Georgia through a long-range and strategic planning committee and make sure that we, as an organization and as individuals, position ourselves in a forward thinking manner to address the problems of medicine in the next

Dr. and Mrs. Ralph Tillman (on the left) visit with Dr. and Mrs. Roy Vandiver prior to the officer's installation. Dr. Tillman is MAG's outgoing Secretary; Dr. Vandiver is our new First Vice President; Mrs. Vandiver is a Past President of the Auxiliary to the MAG.

decade and the next century. Incorporated in this year will be a hard look at the committee structure to be sure that all committees are functioning and that all committees have specific jobs to do this year so as to involve as many members as possible in the working mechanism of our organization. With a beefing-up of the third party payers committee we would hope to stop harassment and intimidation of physicians by hired gun utilization review companies and bring them to the alter of accountability and appropriateness. We hope, with the help of the insurance commissioner, to appropriately address grievances of physicians regarding the so-called bad apples of the private health care insurance industry in our state.

Problems of public health, of medicine and its relationship to environmental issues of health, the continuing drug use crisis and the protection and proper evaluation of athletes participating in high school and college athletics in this state will be some item areas of great concern and hopefully action in the coming months.

The Public Relations Committee, which has done an outstanding job this year, will be utilized to the fullest in bringing attention to the public, common areas of concern that we have with them. We will also tell the story of what the physicians of the State of Georgia are already doing in many areas of the state and how they are already meeting the needs of the homeless, the disadvantaged, and indigent of our state. Perhaps under the sponsorship and coordination of Southern Medical Association or some similar group we will study the feasibility of setting up our own TV studio to produce regional spots for either public service announcements or paid spots based on informational needs to the public so that we truly may enter the 21st century with the ability to produce at a low cost, TV communications with the public from component medical associations and from component specialty associations, for distribution throughout the Southeast. The use of this medium would be, hopefully at some point, self-sustaining. This has been done on an educational basis through the various medical schools, but not from the standpoint of associational activities.

Component county societies and auxiliary units could produce their own TV shots, commentaries or announcements. The potential worth of this to the public as well as internal PR to all component units would be extraordinary. While it is often said that one of the differences between the American physician and his European counterpart is that the American physician must please to a great extent his patients. We must remember that a professional must never yield too much to the demand of clients. As Everett Hughes once said, "Quacks are practitioners who continue to please their customers, but not their colleagues." It is the dual role of being pleasing to the patients in their needs and desires, but at the same time, holding to a professionalism that is appropriate and worthy in the eyes of our colleagues that has set American medicine apart as a unique system in the annals of history that pull our members apart, i.e. competition, must never be allowed to prevail over the common interests that bind us together.

All of these programs will be designed eventually to result in legislative action under the able leadership of our Legislative Counsel led by Dr. Jim Kaufmann and our staff to make the legislators aware of the problems and solutions that medicine faces and can offer. This is

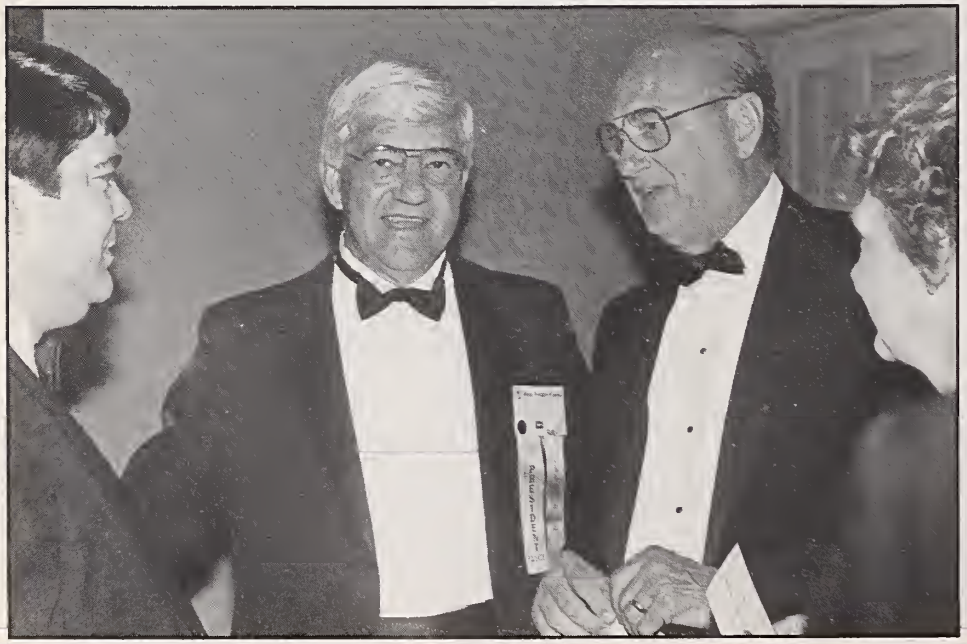
Delegates, spouses, dates, and guests thoroughly enjoyed the festive atmosphere that marked the Installation Ceremony on Saturday night.

the prime job of the Medical Association of Georgia. However, an internal political goal will be to convince all of our members and those who are not members that they must recognize that their autonomy, their ability to practice medicine and render the finest care possible to their patients is no safer than the edicts rendered by the last meeting of the State Legislature or of the Congress of the United States. We exist at the will of the people as interpreted by their elected representatives and we must never forget this. I have often said that the principal difference between the physician and the limited care practitioner is there is no doubt in the mind of the limited care practitioner that he exists at the will of the Legislature whereas the average physician seems to consider himself to have been ordained in his profession by God and subject only to the will of the Almighty.

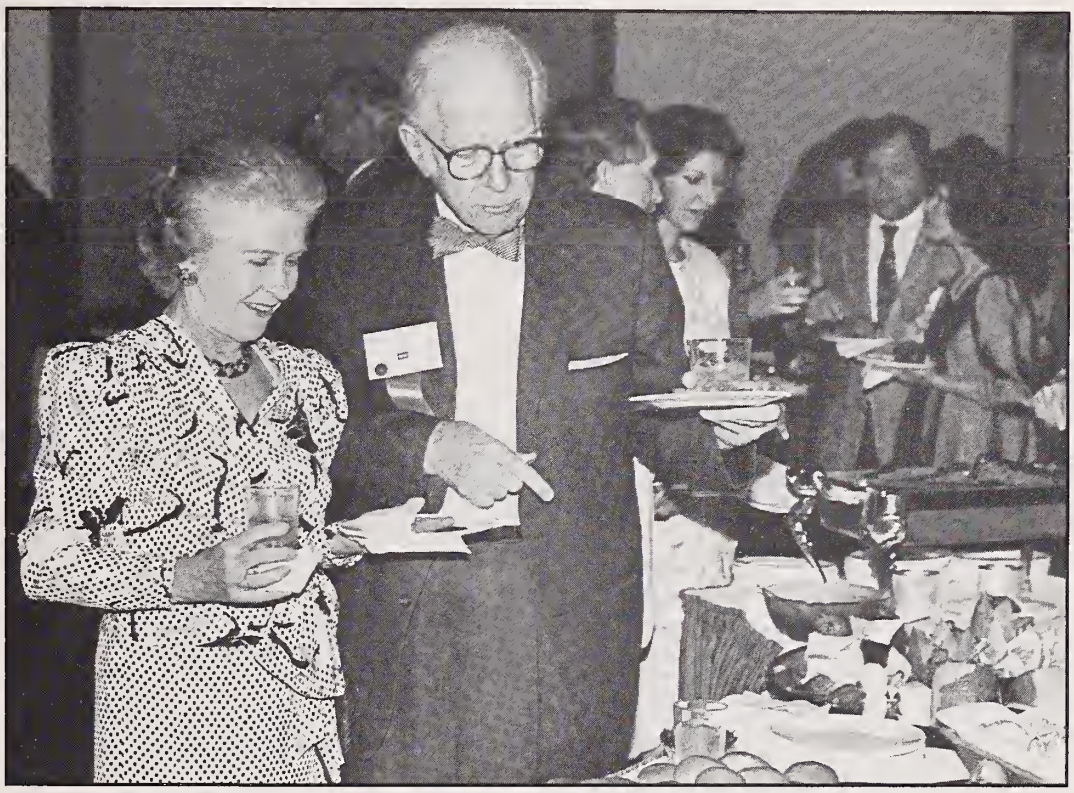
In conclusion, I call upon each of you and each member of the medical profession in the State of Georgia, along with your respective spouse, family and friends to work with me and the Medical Association of Georgia in the coming year and reaffirm the covenant of medical care, concern and trust that has existed between the people of the State of Georgia and their physicians.

Dr. Collins greets Mrs. Charles Hollis from Albany. Mr. & Mrs. Jack Fox from MAG Mutual are also shown.

Dr. and Mrs. Spencer Brewer, Dr. and Mrs. Tom Anderson, and a Gorbachev lookalike?



(L to R) MAG Executive Director Paul Shanor, MAG President Bill Collins, and Dr. and Mrs. Jim Barnett. Dr. Barnett is President-Elect of the Southern Medical Association.



Dr. and Mrs. Harrison Rogers at the Presidents' party Saturday evening.

Dr. and Mrs. James Kaufmann relax at the Saturday night party following a busy House meeting.

Myths or Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true.*

How many did you get right?

Many people are confused about the effects of alcohol on the liver—and ***what you don't know can hurt you.***

A pamphlet on ***myths*** and ***facts*** tells what you can do to protect yourself and your loved ones. For your free copy, send a stamped self-addressed business envelope to:

American Liver Foundation
Box AL
Cedar Grove, N.J. 07009

THE MEDICAL ASSOCIATION OF GEORGIA
Invites You to Join Fellow Physicians and Their Families On New INTRAV Adventure Programs for 1991

IMPORTANT! Although the Medical Association will block space on one departure date per Adventure, INTRAV operates several departures of all its tours. If the date the Medical Association chooses is not convenient for you, call INTRAV at 1-800-234-6900, and ask for alternate departure dates.

Trans-Panama Canal Air/Sea Cruise January 1991
A unique 11-day cruise aboard the new ***Crystal Harmony*** in her maiden season, highlighted by a transit of the Panama Canal, an engineering marvel. Cruise from **Acapulco** on the Mexican Riviera to **Caldera, Costa Rica**; transit the **Panama Canal; Willemstad, Curacao; St. Martin; St. Thomas, U.S. Virgin Islands;** and **San Juan, Puerto Rico.** Optional Acapulco extension. **Free airfare** from most major U.S. cities to Acapulco and return from San Juan
From $2449 per person, double occupancy

Magellan Passage Around South America Air/Sea Cruise February 1991
Sail in the wake of Sir Francis Drake and Ferdinand Magellan on this brand-new, 15-day South American cruise aboard the ***Stella Solaris***. Cruise from **Buenos Aires, Argentina,** to **Montevideo, Uruguay; Puerto Madryn, Argentina;** through the **Strait of Magellan; Punta Arenas, Puerto Montt** and **Valparaiso, Chile.** Optional Santiago extension.
From $3199 per person, double occupancy, from Miami

European Masters April 1991
A ten-day holiday in Europe's great art capitals—**London** and **Paris**. Plus return flight to New York, arriving in half the normal time aboard a chartered Air France Supersonic ***Concorde***.
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> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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References

1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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THE COVER

Cover art by Linda Anderson, of Clarkesville, Georgia. Read more about this remarkable artist on page 579.

William C. Collins, M.D.

Physician-Hospital Relations or "Which Is the Chicken and Which Is the Egg?"

"Although we as physicians can no longer naively trust our hospital administrations to "always do right by us," careful contemplation seems to indicate that both groups have much to lose by infighting and much to gain from cooperation in matters regarding quality patient care."

ONE OF THE ONGOING controversies in the modern medical milieu is the role of the physician and the role of the hospital in these ever changing times. Are we linked to each other in a marriage of convenience or one of mutual satisfaction? The answer to this question holds the key to many of the current socio-economic problems facing this country today.

A historical review shows that only during the last hundred years have hospital and physician had much to do with each other. The early hospitals were primarily religious and charitable institutions that served as a repository for the poor or dying and were not generally regarded as having anything to do with diagnosis or much less recovery. A typical physician prior to the late 1860s could very easily practice a lifetime without setting foot in a hospital.

As Paul Starr points out in his Pulitzer Prize winning book, *The Social Transformation of American Medicine,* hospitals developed from charities, dependent on the gifts of the wealthy to doctor's workshops, financed by payments from patients. The "Boards of Directors," usually wealthy social climbers, became less important to the financial success of the hospitals, and the physician with his patient load became more important. With the advent of the HMOs and other prepaid schemes, hospital administrators have begun to count on these entitities to fill their beds and have concentrated less on the individual practitioner.

Tensions between several hospitals and their physician staffs in this state have deteriorated to a disastrous state of affairs for all concerned. A note of caution exists in many hospital-medical staff relationships and a downright adversarial relationship in many others.

Although we as physicians can no longer naively trust our hospital administrations to "always do right by us," careful contemplation seems to indicate that both groups have much to lose by infighting and much to gain from cooperation in matters regarding quality patient care.

As a noted Hindu philosopher once said, "Help thy brother's boat across the waves, and Lo, thine own has reached the shore!"

NEW MEMBERS

Alfaraz, Carlos R., Family Practice — Muscogee — (Resident) 710 Center St., Columbus 31901

Bellam, Ram, Anesthesiology — Clayton-Fayette — (Active) 1134 Main St., Forest Park 30050

Bellam, Samara S., Internal Medicine — Clayton-Fayette — (Active) 1134 Main St., Forest Park 30050

Broomes, Lloyd R., Psychiatry — Laurens — (Active) 1702 Murphy Lane, Dublin 31021

Brown, George W. Brown, IV., Family Practice — MAA — (Active) P.O. Box 548, 401 Carlton Rd., Palmetto 30268

Chadband, Robert B., Endocrinology/Geriatrics/ Diabetes — Richmond — (Active) BD 250 Medical College of Georgia, Augusta 30912

Cohen, David A., Neurology — MAA — (Active) 690 St. Fillans Court, Alpharetta 30201

Dawson, Lawrence J., Emergency Medicine — MAA — (Active) 4972 Lakeland Drive, N.E., Marietta 30068

DeMarco, Thomas J., Internal Medicine/Gastroenterology — Cobb — (Active N2) 2491 Paces Ferry Rd., Ste. 201, Smyrna 30080

Erne, Jerel J., Psychiatry — Richmond — (Resident) 3213 Crane Ferry Rd., Augusta 30907

Farmer, Timothy L., Internal Medicine — Bartow — (Active) 962 Joe Frank Harris Pkwy., Ste. 104, Cartersville 30120

Franco, Carlos M., Internal Medicine/Hematology/Oncology — MAA — (Active) 993 Johnson Ferry Rd., Bldg. D. Ste. 430, Atlanta 30322

Gordon, Anthony K., Diagnostic Radiology — MAA — (Active N2) 465 Hembree Rd., Roswell 30076

Griffis, Mark, Family Practice — Muscogee — (Resident) Box 39 Center St., Columbus 31904

Gupta, Krishan G., Urology — Clayton-Fayette — (Active N1) 150 Medical Way, Ste. A, Riverdale 30274

Kajani, Mirza A., Internal Medicine/Gastroenterology — Coweta — (Active) Newnan Medical Plaza, Ste. 105, 58 Hospital Rd., Newnan 30263

Kim, C. Kurtis, Pathology — Clayton-Fayette — (Active) 107 Upper Riverdale Rd., Riverdale 30274

Lind, Ronald M., Anesthesiology — Muscogee — (Active) 5813 Neassie St., Columbus 31909

Madabhushi, Vasudevan, General/ Vascular Surgery — St. Johns Parish — (Active) Liberty Memorial Hospital, Hinesville 31313

McClendon, James F., Psychiatry — MAA — (Associate) 550 Fairburn Rd., #A-2, Atlanta 30331

Miller, Bruce E., Anesthesiology — MAA — (Active N2) 1920 Oak Branch Way, Stone Mountain 30087

Pollock, Mark T., Internal Medicine/Pulmonary Diseases — MAA — (Active N2) 478 Peachtree St., N.E., Ste. 107-A, Atlanta 30308

Quinif, Alice M., Diagnostic Radiology — Colquitt — (Active) 128 Country Lake Lane, Thomasville 31792

Rao, Sanjeeva, Internal Medicine — Spalding — (Active) 740 Kay Street, Jackson 30233

Rodriguez, David F., Internal Medicine — MAA — (Active N2) 514 Tuxworth Circle, Decatur 30033

Rogers, Steven G., Radiology — Richmond — (Active) 3623 J. Dewey Gray Circle, Ste. 112, Augusta 30909

Stewart, Mark J., Anesthesiology — Richmond — (Active) 2271 Essex Drive, Augusta 30904

Vega, Manuel A., Cardiology — Clayton-Fayette — (Active) 157 Glen Eagle Way, McDonough 30253

Walters, Gordon L., Cardiology — Richmond — (Active) 818 St. Sebastian Way, Ste. 311, Augusta 30901

Wortham, Doris J., Pediatrics — Cobb — (Active N2) 833 Campbell Hill St., #112, Marietta 30060

PERSONALS

Bibb CMS

James W. Alley, M.D., Director of the Division of Public Health of the Georgia Department of Human Resources, was the commencement speaker for the 22 students receiving M.D. degrees at the Mercer University School of Medicine.

MAG Delegates to the June AMA House of Delegates met each morning at 6:30 at a Breakfast Caucus to discuss the resolutions and reports being considered by the House. Among the subjects discussed were Georgia's problems with Medicare, the development of a model basic benefit package for health insurance, Living Wills, and Health Access America.

Shown here, left to right, are Dr. Cyler Garner, Gordon; Dr. Bill Collins, Atlanta; Dr. Joe Nettles, Savannah; Ms. Priscilla Daves, MAG PR Director; Dr. Bill Logan, Atlanta; Dr. Richard Cohen, Austell; Dr. Carson Burgstiner, Savannah; Dr. Louis Felder, Atlanta; and Dr. Joe Stubbs, Valdosta.

One of the brightest highlights of the AMA House of Delegates for MAG Delegates was the election of Douglas Skelton, M.D., (center) Dean and Provost of Medical Affairs of the Mercer University School of Medicine in Macon, to the AMA Council on Scientific Affairs. This represents the first time in the history of the AMA that a candidate who was not a delegate to the AMA House won on a first run for an office.

Shown here with Dr. Skelton are (left to right) MAG's Delegates to the AMA, Dr. Bill Collins, Atlanta; Dr. Charlie Hollis, Albany; Dr. Skelton; Dr. John Watson, Columbus; and Dr. Emory Bohler, Brooklet.

Cobb CMS

Marietta urologist **Harold P. McDonald, Jr., M.D.,** was elected second vice president of the American Society of Outpatient Surgeons at its annual meeting last April in San Diego.

Medical Association of Atlanta

William E. Silver, M.D., traveled to Monserrat, West Indies, where he lectured to a group of surgeons of soft tissue surgical techniques on and about the face. A tour of the medical facilities revealed that Monserrat's only hospital had been damaged badly by Hurricane Hugo and that the medical library was totally destroyed. The medical community is in desperate need of any type of basic medical, surgical, and nursing books. Please contact Dr. Silver (404-457-6303) if you have any books to donate to the Monserrat Hospital. These can be "old" books or previous editions — any amount will help. Also, the major grammar school library lost most of its books, so any children's books would also be appreciated.

Hall CMS

Ellis B. Keener, M.D., F.A.C.S. a Gainesville neurosurgeon, was elected President-Elect of the Georgia Chapter of the American College of Surgeons last March.

Richmond CMS

E. A. Saunders, M.D., a pediatrician from the Medical College of Georgia, was honored at his recent retirement by proclamations from Mayor John Knox of Waycross and Governor Joe Frank Harris. Dr. Saunders was so honored for his 23 years of service to the Waycross community to which he traveled monthly to provide pediatric care to the children of southeast Georgia. The children came from a 13-county area and were seen by Dr. Saunders at the DAISY clinic.

Whitfield-Murray CSM

Atulkumar D. Patel, M.D., of Dalton, has been certified a diplomate in medical oncology by the American Board of Medicine. Dr. Patel is also certified in internal medicine.

OTHER NEWS

DeKalb County

The DeKalb Teenager Pregnancy Task Force: The Oakhurst Project has been selected as the winner of the 1990 AMA National Congress on Adolescent Health Award for the category of Coordinated Comprehensive Health Education & Prevention Programs. This program was selected as the best in its category by three independent reviewers with expertise in adolescent health and program development.

Crawford W. Long Museum Activities

On the second Sunday of each month, a special program will be offered at the Crawford W. Long Museum in downtown Jefferson. Programs will focus on area history, folk crafts, ages, designed to entertain as well as educate.

The SECOND SUNDAY series joins two other special programs now in their third year. The last week in March is designated DISCOVERY WEEK in celebration of Dr. Long's discovery of anesthesia on March 30, 1842. Activities focus on his discovery and its significance in the world of medicine. The first week in November is celebrated as CRAWFORD W. LONG DAYS, taking a look at life during the 1800s.

Since its expansion in 1987, the Crawford W. Long Museum has enjoyed increased visitation and interest. Last year, over 3200 people toured the museum complex — a record number — and learned about Dr. Long's discovery of anesthesia. The hours are 10 AM to 1 PM and 2 PM to 5 PM Tuesday through Saturday, 2 PM to 5 PM Sundays, closed Mondays.

The Long Museum is located in downtown Jefferson, off US 129 between Athens and Gainesville, five miles south of I-85 at Exit 50. Admission is by donation, and groups are requested to call ahead. For further information, call 404/367-5307.

DEATHS

John Lawson Elliott, M.D., of Savannah, who was instrumental in founding the local Tuberculosis Association and the Community Cardiovascular Council, died last May after a long illness. He was 91.

Dr. Elliott graduated from Emory University of Medicine in 1923. He interned at Grady Hospital in Atlanta, and at the U.S. Marine Hospital in Boston.

He began practicing medicine in Savannah in 1925 when tuberculosis was a relatively common but hidden disease. He and other local medical professionals started clinics in Savannah, funded by private donations and income from the sale of annual Christmas seals. Eventually, the city and county governments established a sanitarium at Bona Bella for tuberculosis treatment. He was appointed its medical director, serving for many years.

In 1977, members of the Southeast Branch of the Georgia Lung Association gathered to honor longtime volunteers and made a key tribute to Dr. Elliott, who has volunteered for 50 years.

He helped organize the American College of Chest Physicians and was founder of the Chatham Unit of the Georgia Heart Association and the Community Cardiovascular Council. He also directed a collaborative community stroke study of Chatham County from 1969 to 1972. Until his death, he remained program medical director of Candler's Cardiac Rehabilitation program, which he helped start in 1978.

Dr. Elliott was the founder and a charter member of Savannah Blue Cross and former chief of staff at Candler. He served on the staff of Candler since the 1920s and also was on staff at Memorial Medical Center and St. Joseph's Hospital.

He was past president of the Georgia Medical Society and the Georgia Heart Association.

Dr. Elliott chaired a committee on Economics and Insurance for the Medical Association of Georgia which worked a plan to cover the cost of catastrophic illnesses, a forerunner of our insurance program which culminated in the Georgia Plan. For this he received MAG's Hardman Cup Award in 1974.

F. Levering Neely, Sr., M.D., of Atlanta, retired chairman of the Department of Medicine at Piedmont Hospital and a leader of two local volunteer groups, died last June of cardiac arrest at his home. He was 77.

Dr. Neely specialized in internal medicine, gerontology, and chest diseases. He was chairman of Piedmont Hospital's Department of Medicine in 1973-78, and president of its medical staff in 1951. Overall, he was associated with the hospital for 41 years, from 1946 until retiring in 1987.

He was a co-founder of two local groups to aid shut-ins and the homeless. The first, North Atlanta Senior Services, delivers "Meals on Wheels" and does handyman work. The second, Congregations of Affordable Housing, builds homes.

Dr. Neely and his late wife helped start a medical clinic in Vine City, and he traveled to Afghanistan to do volunteer medical work for CARE-Medico, an international organization. He also donated his services at a medical clinic at Central Presbyterian Church and organized the Half-Baked Hams, an amateur musical group that entertained at retirement homes.

Dr. Neely graduated from Emory University in 1934 and received his medical degree from Johns Hopkins School of Medicine in 1938. He did postgraduate work at Columbia Presbyterian Medical Center and Bellevue Hospital, both in New York.

He received the Aven Citizenship Award of the Medical Association of Atlanta for "exemplary service to the community" in 1986; it is the group's highest award for local physicians. In 1989, Dr. Neely received a Governor's Community Service Award from Gov. Joe Frank Harris.

Dr. Neely was a former member of the board of directors of Wesley Woods Center, and an adviser to the board of the Visiting Nurses Association at Piedmont Hospital. He published *The Genes of Ambition: A Multi-Generational Saga,* a book about the Neely family, in 1986.

John W. Turner Jr., M.D., a retired surgeon in Atlanta, died of heart failure last June at the age of 102.

Dr. Turner was a consultant and chief of staff in surgery at Georgia Baptist Medical Center and St. Joseph's Infirmary and was on the staff at Crawford Long Hospital from 1940 until he retired in 1970. He had a private practice from 1915 to 1940 and served in the U.S. Naval Reserve Medical Corps in World War I from 1917 to 1919.

He received a bachelor's of pharmacy degree from Mercer University in 1907. He worked as a pharmacist for a year, applied to medical school and in 1913 graduated from Tulane University.

Dr. Turner was past president of the Fulton County Medical Society, and he belonged to several other professional organizations. He was a fellow of the American College of Surgeons, the International College of Surgeons and the American Society of Abdominal Surgeons. He was also a diplomate of the American Board of Abdominal Surgeons.

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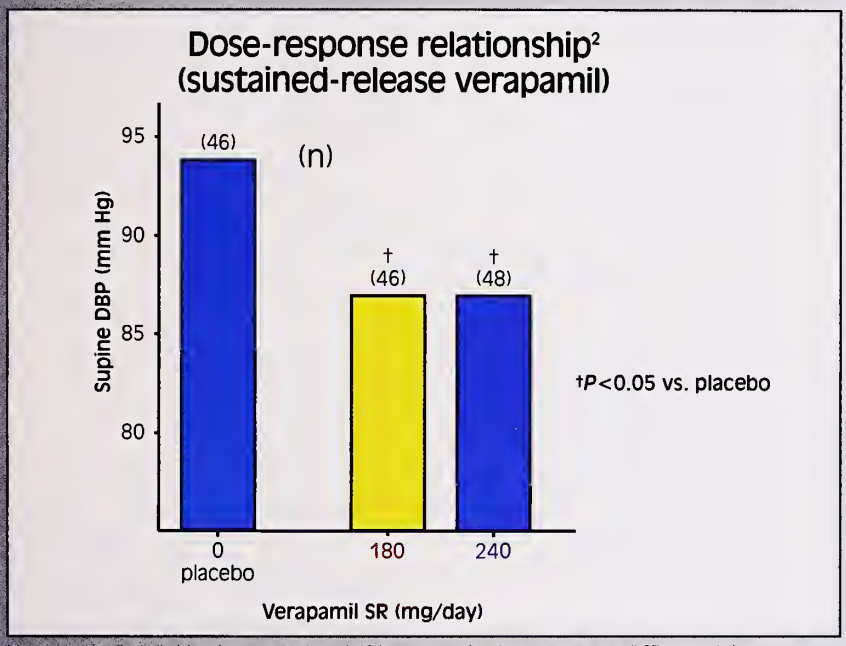

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

References:

1. 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.
2. Data on file, G.D. Searle & Co.

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About the Cover Artist:

LINDA ANDERSON

"When I received the gift to paint," said folk artist Linda Anderson, "there was an unveiling of my eyes. I began to see how trees were shaped; they're all shaped differently."

Ms. Anderson paints trees in a distinctly elegant graceful way. She positions leaves on the fringes only, leaving the inside skeleton of branches exposed to reveal the trees' underlying structures. That she sees beneath the surface is apparent in all of Ms. Anderson's simple, straightforward works. Her images of friends and family involved in the everyday rhythms of rural life are imbued with an undercurrent of sharp understanding. Their quiet dignity evokes the spirit of the people of the North Georgia mountains, many of whom endure poverty and hardship with faith, perserverance, and courage.

Ms. Anderson is familiar with some of those hardships. Born in a three-room, dirt-floored house in Floyd County, she moved as a child to Habersham County, where she lived in rural rental houses with her parents, three brothers, one sister, and her grandmother. Her father had cancer and was unable to work, so her mother supported the family by working as a maid. She spent most of her time in the fields and woods — hunting, fishing, and doing farm labor with her younger brother.

Her father died when she was in the eighth grade, and she had to drop out of school to go to work — first as a maid, then as a nurse's aid. She eventually was able to save enough money to take a nursing course, and later became a licensed practical nurse.

An accomplished wood carver, carpenter, and furniture-maker, she began painting in 1982. She did so as a result of a personal tragedy.

"At that time, my older daughter suffered a stroke which left her physically and mentally impaired, so that she required constant attention. Unable to leave her bedside to work, I took up needlework and quilting — things that I could do in her room. Having some left-over paints that I had used on some handmade stuffed animals, I decided to try to paint a picture. It was such a restful thing, taking me back to more pleasant times, that I just continued with it. All my paintings are events that took place in my life or things I'm familiar with. I feel my art is a gift presented to me from the Almighty. It is my escape into it that keeps my sanity." All of her work is from memory, recalling happy times, family gatherings, community activities, and biblical stories.

Now, in what seems the blink of an eye in the context of most painters' careers, this self-taught artist's work is known and sought after across the Southeast, and is beginning to receive recognition in other parts of the country as well. Admirers attribute her rapid success to her keen understanding of her subject matter. Asked about her phenomenal success, she replies, "It was meant to be. When you feel that you've gone the last mile you can go, and a new door opens up, there's got to be something higher than you doing it."

One Person Exhibitions

1988 — Anderson College, Anderson, South Carolina
1986 — Alexander Gallery
1985 — Swan Coach House Gallery, Atlanta Historical Society, Atlanta
1984 — Alexander Gallery, Atlanta
1983 — Alexander Gallery, Atlanta

Group Exhibitions

1988 — Outside the Main Stream; Folk Art in Our Time. Atlanta High Museum

1987 — Opening Exhibition, Primativo Gallery, San Francisco, California

1987 — "Inner Resources," Marietta Cobb Fine Arts Center, Marietta, Georgia

1987 — Georgia Department of Industry and Trade Art Exhibit, New York City

1986 — "Southern Artist" — 1986 Secca. Winston Salem, North Carolina

1986 — "Visual Arts: Southeast," Atlanta

1985 — "Art for Children" — Atlanta High Museum of Art, Atlanta

1984 — USA/Portrait of the South, Rome, Italy

Publications

1990 — Atlanta Dogwood Festival — Poster, Atlanta

1987 — "Life's Truest Treasures." Cover, *Guideposts* Publication, Carmel, New York

1987 — June *Guideposts,* "An Enchanted Place." By Sue Monk Kidd, New York City

1987 — Spotlight on Georgia Artists — Poster, Atlanta

1986 — State of the Arts — T.V. Documentary

1985 — Sec 10. "Linda Anderson Transulates Her Visions to Canvas." Bo Emerson, *Atlanta Constitution,* Atlanta

1985 — "Linda Anderson." By Marianne Lambert, *Peachtree Papers,* Atlanta

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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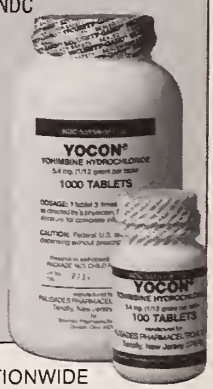
References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Whether to Publish Sanctions

Charles R. Underwood, M.D.

THERE HAS BEEN some discussion recently concerning publication in the *Journal of the MAG* of actions taken by the Composite State Board of Medical Examiners (the "Board"). Specifically, it has been suggested that we publish the names of individual physicians and any sanctions levied or rescinded by the Board. This matter has recently been discussed at length by the Executive Committee of the MAG which is the Publications Committee of the *Journal.* It is our opinion that the publication of such precise information would have little value to either the individual physicians concerned or the readership of the *Journal.* It is then our considered judgement that such publication will not be pursued. The final decisions and actions of the Composite State Board of Medical Examiners is public information and any interested or concerned individual can obtain that information by contacting the Board as follows: Andrew Watry, Executive Director, Composite State Board of Medical Examiners, 166 Pryor Street, S.W., Atlanta, GA 30303.

POST HOC

Silently, so silently,
A star breaks dark monotony.
Salamanders crease the slime,
As protozoa bide their time.

Silent winds and lifeless beaches
Desolate the lonely reaches
Of the night. No hand to stir
The waves with an Excalibur.

Phosphorescent phantoms rise
To view an earth that sought the skies.
Silently, silently,
The faded moon weeps on the sea.

ABOUT ATOMS

Why the excitement about atoms?
When will the furor leave?
It seems to me that women
Started splitting Adams with Eve!

SUNSET

The sun rides low in the saddle of the mountains,
Kicking a dust of shadows into the valleys.
Wearily against the neck of the slopes
He leans, riding his brightly branded herd
Of thundering clouds across the last horizon —
Now toward home with steadily quickening gait,
Corraling day as coyote stars awake.

JOHN RANSOM LEWIS, M.D.

Dr. Lewis, a plastic surgeon in Atlanta, is Georgia's Poet Laureate.

In Pursuit of CME

"To study medicine without books is to sail an uncharted sea. To study medicine without patients is to never go to sea at all."

WILLIAM OSLER

"We cannot understand the megatrends of the 1990s without acknowledging the metaphorical and spiritual significance of the millennium. Most important, we must recognize its power to evoke our most positive, powerful visions alongside our most terrifying nightmares. In the 1990s apocalyptic themes will emerge and reemerge with stunning regularity. Disaster, it seems, is always just around the corner; the superpowers, having just signed a nuclear arms agreement, come face-to-face with the 'greenhouse' effect.... On a secular level, the millennium has come to mean a golden age in human history, a time to close the door on the past and embark upon a new era.... As we approach the year 2000, the millennium is reemerging as a metaphor for the future. In the biblical millennium the establishment of a heavenly kingdom on earth could occur only after the final battle between Christ and the Antichrist, the clash of complete opposites. Like the ancient drama, the modern millennium ignites our vision for a better world alongside our nightmares of the world's end. The dichotomy is ever-present. Perhaps this is why arms control cannot eliminate our fear of nuclear weapons, why declining unemployment figures, record breaking new business starts, and new job creation fail to calm fears of a depression in the 1990s. Beneath the specter of nuclear weapons is a growing sense of hope that if we can just 'make it to the year 2000,' we will have proved ourselves capable of solving our problems and living harmoniously on this fragile planet.... The meaning of that great symbol, the millennium, depends entirely on how it is interpreted. It can mark the end of time or the beginning of the new. We believe the decision has already been made to embrace its positive side. Within the hearts and minds of humanity, there has been a commitment to life, to the utopian quest for peace and prosperity for all, which today we can clearly visualize. Humanity is entering a decade-long race to confront the great challenges remaining in hope of making a fresh start in the year 2000. The 1990s will be an extraordinary time. The countdown — 1992, 1993, 1994 —is just about to begin. Get ready. You possess a front-row seat to the most challenging yet most exciting decade in the history of civilization."

Megatrends 2000
JOHN NAISBITT &
PATRICIA ABURDENE

"Thus creativity and innovation, for all their vaunted liberties, are deeply tied to continuities human and natural. We cannot innovate in science without enlarging our appreciation for timeless laws. We cannot innovate in art or philosophy without renewing contact with ancient issues. I have compared innovative thinking to a voyage, and its territory to a frontier. But paradoxically it is also a homecoming, a heroic effort, by individuals exiled in space and time, to realize principles of solidarity and permanence. Because of the mysterious doubleness of creative identity, neither the typical liberal attitude nor the typical conservative attitude toward innovation is wholly constructive. Modern liberalism endorses innovation as the medium of radically transfiguring improvement. Modern conservatism distrusts innovation, instead supporting stability (preservation of the status quo) or rededication (return to values putatively held in the past). Liberalism and conservatism would offer us valid alternatives — and even prove happy complements to each other — if innovative discovery were purely and simply the discovery of the new. But this is not the case. If the real subject of discovery is not novelty but permanence, then real innovation lies not in the denial of permanence but in the evolution of our modes of perceiving it. Ill at ease with continuity of any

sort, modern liberalism is insensitive to many forms of valid innovation. Modern conservatism, on the other hand, misinterprets as monolithic stability a continuity that can be retained only through evolving methods. Innovation is thus neither liberal nor conservative. At heart, it is decidedly more primitive. It belongs to the poet and the hero."

The Grace of Great Things
ROBERT GRUDIN

It was an unsettling, a somewhat annoying uneasiness, which took me to Boston this past Spring. I had gone there for Continuing Medical Education. For "C.M.E." She is an ever constant mistress and demanding companion, she is, this compulsive desire to stay abreast of advancing knowledge. This relentless restlessness to "continue" our medical education. It will not let us alone. We seem to dread the simple ignoring of it to the point that we pass laws both within our medical organizations as well as at state and federal governmental levels to assure ourselves and guarantee the public that we are "keeping up." We travel about the earth mixing study with pleasure in a frenetic fear that she will escape us should we dare relax and slumber.

And so it was that this restless pilgrim traveled this Spring to Boston. It is as going to the mountain, to the fountain head, to be in this Mecca of learning. They simply open the windows there, and authority flows in. Harvard, the mere name strikes fear in the heart of the ill prepared Southern student and sojourner. We had been reared, grown up, in the cloistered and protected South where Harvard resided in our vocabulary as some intellectual Shangri-la populated by a race of individuals too distant to be approached. The notion persisted until one day when I found myself in the midst of an intern class consisting of nine Harvards, myself and my Emory friend, and a smattering of others. I shuddered at the thought of competing with these giants. However, no longer than several months later we had taught them the basics of starting IV fluids and other such practical matters long a fact of daily survival in the cauldron of the Emory-Grady student survival. They caught us, of course, as the months wore on. Indeed, they caught and surpassed us, teaching us all that unescapable lesson that one must in some way meld learning with wisdom with effort and with skill should our best performance be achieved.

Osler knew that. He told us such in one of the essays when he wrote, "To study medicine without books is to sail an uncharted sea. To study medicine without patients is to never go to sea at all."

"... "within 10 years regarding the treatment of breast cancer, we surgeons will be little more than an occasional consultant to the oncologist and the molecular biologist or to someone else not yet defined."

They had made an interesting change of location, the Harvard people had, and the course was comfortably quartered in the Ritz Carlton Hotel hard by the Public Gardens. Here one finds only one of the many vagaries of continuing our medical education. A well structured and didactic array of knowledge presented by world renowned authorities right in the bowels of a magnificent hotel. "And this is the hardship I must survive to continue my search for knowledge?" I ask myself. The shops, the art galleries, the antiquarian book stores, they all lure one within walking distance. The Public Garden is but a street crossing distance.

I wandered there early one morning as day was barely breaking, being reminded of my Southern heritage as I came upon a statue sitting upon a hillock. At the base of the statue was the inscription, "To the men of Boston who died for their country on land and sea in the war which kept the Union whole — Destroyed slavery and maintained the constitution — The grateful city has built this monument that their example may speak to coming generations."

We all seek the perpetuation, the refinement, of our basic medical education, its continuum, in a great variety of ways. Such comes for some of us through books and journals. For others, the most benefit is derived by means of courses and meetings. By tradition we have found these at our academic institutions but the recent introduction and development of laparoscopic cholecystectomy has shown us that advances in our knowledge and technical capability may as well spring from the private community of physicians. It is,

this procedure, a case study in the manner by which medical advances are made.

With the medical literature devoid of basic research or series of cases to support or justify the procedure, with the majority of academic institutions viewing the matter with disdain, one finds the private surgical community developing and presenting a new technique for an ancient and established operation and with surgeons, this one included, private and academic alike rushing head first into the lecture halls and animal laboratories as though the morrow held no hope save as seen through the laparoscope.

Take no solace, you cognitive physicians, for such may well descend upon you in the morning. There is something new and different here. One can but wonder if we are not seeing in this affair a movement away from tradition as the world of the entrepreneur with its market driven forces moves into the staid and fixed world of medical advance and of Continuing Medical Education to say to us, "We have a better way, a faster and more efficient and cost effective way, to accomplish an end." Surely, if nothing else, it says to us all, and we must heed the warning, that we are living in a world of permanent change.

And so it was that I found myself ensconced in the Mecca of academia and awash with data, studies, trials, and protocols, themselves pointing a wavering finger into an uncertain future. Where, indeed, were the crystal clear answers to those perplexing and agonizing problems which in my world stood before and challenged me?

"... the recent introduction and development of laparoscopic cholecystectomy has shown us that advances in our knowledge and technical capability may as well spring from the private community of physicians. It is, this procedure, a case study in the manner by which medical advances are made."

I had come here for guidance, seeking precise solutions. Expecting from these Gods of Learning, these denizens of knowledge, not further uncertainty and querulous debate but precisely marked road maps by which I might travel the road ahead. Such was not forthcoming. I received instead a lesson itself as clear and precise as the answers which I had sought.

The first, that my world of general surgery, and it might as well have been internal medicine or others, was crumbling about me. Crumbling, perhaps evolving, would serve best, as the world of resarch and investigation redefined the parameters of the world, of the specialty, in which I pass my days. And further than this, that I must redefine, alter, and change, myself and my technical and cognitive skills, to exist comfortably and efficiently in that world.

The second, and perhaps it holds greater impact, that my future in medicine, and indeed had my past, would hold no clear and precise answers for those patients and their physical and emotional afflictions to which I would be asked to address myself. No road map to be purchased at whatever price nor in whatever Hamlet or Mecca to guide my path. I saw closely at last, if not before, that we live our lives in constant search for answers, constantly questioning and examining ourselves, else we fall prey — not only we but also those who trust their health to us — we both fall prey to the deadly intransience of thoughtless performance.

"I will predict for you," he said as my voyage into C.M.E. came to its anchoring place again, to its *fondeadero,* "that within 10 years regarding the treatment of breast cancer, we surgeons will be little more than an occasional consultant to the oncologist and the molecular biologist or to someone else not yet defined." This he said to one who for many years had removed the female breast for that disease and with complete conviction that such was the appropriate and only manner in which to control it.

And so it was that I returned home with the world of my surgical past swirling about me. "Where, or where, are the road maps?" I asked. "Drawn on the cumulus clouds of your imagination," she answered.

CRU

LETTERS

Dear Editor,

I recently saw a copy of the February [1990] issue of the MAG *Journal*, and I am writing to thank you for a thoughtful, informative look at nursing. I particularly appreciate the fact that you asked nurses to talk about nursing, rather than presenting nursing solely from a medical perspective.

I thought Dr. Netter's editorial was an excellent illustration of the inter-dependent and collegial relationship that should exist between medicine and nursing. RCTs are not the answer to the nursing shortage, but I think that a good many more physicians who feel as Dr. Netter does would certainly help.

The cover of the *Journal* was wonderful, and it made me think that it's a shame that the Statewide Joint Practice Committee Between Medicine and Nursing no longer exists. I think it would be a step ahead for health care in our state if nurses and doctors came together in an atmosphere of mutual respect and cooperation to tackle some of our pressing problems in Georgia.

I hope many other nurses had the opportunity to see your excellent February issue as well. Thanks again!

Cordially:
Fran Beall, R.N.,C.
Bogart, Georgia

Dear Editor,

As an oncologist and student of mathematics, I would like to applaud Dr. Mueller's admonitions regarding the potentially fallacious interpretation of the adjuvant chemotherapy literature as presented in his article, in Volume 79, June 1990. In his article, he has pointed out some very appropriate illustrations of innumeracy, the mathematical counterpart to illiteracy. I am a radiation oncologist, and our training is steeped in learning to skeptically and carefully review our own literature as well as that of any other specialists. A useful premise has grown out of my experience which I call Tidwell's Maxim: "90% of everything is B.S." It is up to me to prove to myself what is not.

Despite all my applauding of his warnings, I do take issue of Dr. Mueller's spinning off into a discussion of ethics in adjuvant treatment. Dr. Mueller says that he finds it not in the classic tradition of ethical medical practice to recommend to any woman a drug or treatment *that can never be seen to be to her benefit,* unless the outcome from that therapy is so overwhelmingly superior that it no longer requires statistical analysis.

To me, that statement is too simplistic for words. Mueller can be interpreted to mean that, at some point in time, we actually stop analyzing ourselves. This is totally against ethical principles in my consideration. We must always be observing ourselves analytically and ethically. When I recommend a treatment to a patient, I always have a reason, and I discuss that reason with the patient and together we "pays our money and takes our chances," and if that patient is in a protocol study, then that treatment is analyzed to the best of our ability taking care to observe the best possible statistical procedures.

I believe that Dr. Mueller can be construed as being nihilistic or possibly, unethical, if he withholds from a patient a treatment which has shown to be of benefit to an aggregate group of patients to which this patient could be included.

I do, however, respect his position as a skeptical analyst of the literature but I cannot agree with his simplistic and negative conclusion of "NO". Most times we will not know in any particular individual whether a treatment is going to be of benefit since we are, on the basis that others in aggregate studies have been helped, treating "probable" microscopic locoregional or distant disease "prophylactically" assuming that it is there.

Very truly yours,
Thomas J. Tidwell, M.D., P.C.
Radiation Oncology
Griffin

Dear Editor,

In reference to Drs. Ferguson, Feinstein, and Pendergrass' article in the June, 1990, issue regarding lumpectomy and radiation therapy for breast cancer, I would like to point out a severe difference and a need for analysis of reasons behind the methods of treatment used for breast cancer in Atlanta versus, say, Philadelphia and Boston.

At a recent meeting of radiotherapists at the Mayo Auditorium at the University of Minnesota, radiotherapists from the Joint Center for Radiation Therapy in Boston reported that 3 out of 4 women treated for breast cancer in their city elect to have lumpectomy and radiation. The figures for Philadelphia are also much higher than those in Atlanta. If cancer of the breast is ubiquitous, nongeographically related, and can be analyzed in national clinical trials, then why should there be such a difference in modalities of treatment between the women of Atlanta and those of other major cities? Is Atlanta farthest down stream in the flow of knowledge or is

Philadelphia and Boston going off the deep end into modern medicine?

The European and Canadian literature have long ago demonstrated their satisfaction that lumpectomy and radiation therapy is a satisfactory equivalent approach in selective cases. Saving their breasts seems more important to women in other parts of the globe and in the United States. It would appear that Southern women feel less threatened by the loss of their breasts. Perhaps, a psychological study should be performed to determine if Southern women have an unusually strong antipathy to their breasts (maybe more tender fibrocystic disease) or maybe they are more docile in following cues given off by their surgeons at decision time.

Very truly yours,
Thomas J. Tidwell, M.D., P.C.
Radiation Oncology
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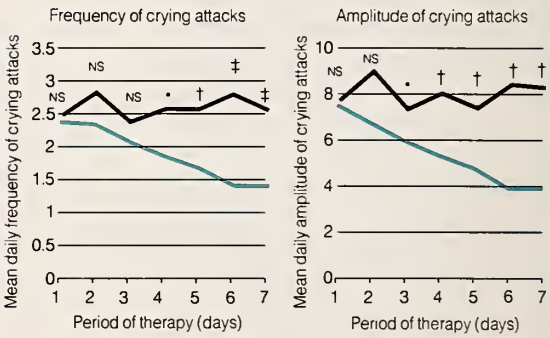

p values (active vs. placebo) NS = Not significant •$p < 0.05$ †$p < 0.02$ ‡$p < 0.01$

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1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner.* 1988;232:508.

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PZ24

Cost Control Measures Lead to Decrease in Hospital Admissions

Fewer people were admitted to community hospitals in 1989 than in any other year since 1973, while a record-breaking number of outpatient visits were recorded, according to American Hospital Association data.

Cost containment efforts, new payment policies, technological advances and a growing emphasis on preventative care contributed to this shift. Hospitals responded to the change by closing more than 70,000 beds between 1983 and 1989, about 7.3 percent of all beds.

"During the 1980s, hospitals have done a superb job of meeting patients' needs and delivering quality care in a rapidly changing environment," said AHA President Carol McCarthy. Yet she cautioned, "This high standard is jeopardized by rising expenses, increasing indigent care costs and continuing Medicare and Medicaid shortfalls that erode needed financial stability."

Although total admissions dropped to 33.2 million, AHA's National Hospital Panel Survey shows that the number of patients over age 65 actually increased during the last three years. Occupancy rates have remained fairly steady over the last five years, fluctuating between a low of 63.6 percent in 1985 and a high of 64.9 percent in 1989.

In 1989, hospitals confronted an inflation rate of 7.4 percent in the goods and services needed to provide care, the steepest increase since 1982. Sharply higher fuel and utility costs, which rose at more than triple the 1988 rate, and surging labor costs pushed up expenses.

Hospitals, coping with staff shortages, offered higher salaries and incentives like flexible hours and hospital-based day care centers to recruit and retain needed personnel. This contributed to the 1989 increase in payroll and employee benefits.

Court Upholds Hospital Challenge of Medicaid Rates

The U.S. Supreme Court has reaffirmed by a 5-4 vote the right of hospitals to challenge state Medicaid payment policies in federal court.

The high court's ruling makes available for the first time a forum to review Medicaid plans that are underfunded, according to Frederic J. Entin, AHA's senior vice president for legal and regulatory affairs. "Without the opportunity to go to court, individual providers would never be able to challenge those rates," he said.

In the case before the Supreme Court, lawyers for the commonwealth of Virginia questioned whether the Virginia Hospital Association (VHA) in 1986 could legally challenge Virginia's Medicaid rates. They contended that only Medicaid recipients could dispute the program's policies, but federal district and appellate courts in Richmond disagreed.

The hospital association maintains that Virginia's reimbursement rates are "illegally low," which violates a federal law requiring state Medicaid programs to make "reasonable and adequate payments" to "efficiently and economically run hospitals." Virginia reimburses hospitals 71 cents for every $1 they spend to treat Medicaid patients.

The U.S. District Court in Richmond is scheduled to begin hearings on the 4-year-old VHA lawsuit on Dec. 17. If the VHA is victorious, Virginia's hospitals could receive more than $23 million in additional Medicaid matching funds from the state and federal government each year.

Unoccupied Beds Cost $3.1 Billion Yearly

On any given day, approximately 21 percent of staffed hospital beds — 194,000 — are unoccupied, costing health care facilities $3.1 billion annually, a recent study suggests.

That figure is below previous government estimates of 330,000 excess beds costing $10 billion, according to the study conducted at Johns Hopkins University, Baltimore, for the American Healthcare Systems Institute.

David N. Sundwall, M.D., vice president and medical director of the institute, said the dilemma of eliminating unused beds in rural hospitals is that "you could wipe out health care delivery on a regional basis."

Henry Bachofer, vice president for the AHA's Office of Health Finance and Data Analysis, said the study is useful in distinguishing the difference between empty beds and excess beds. He said the previous estimate of 330,000 is the number of beds reported to be empty. But 194,000 is the number of beds that are empty but are not likely to be needed.

"I think there is the tendency to subtract the average daily census from the total number of licensed beds, which is totally inappropriate," he said. "The study is likely to overstate the cost of empty beds. Furthermore, as the authors note, eliminating the excess beds will not yield savings as the capital investment already has been made."

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CALENDAR

SEPTEMBER

6-9 — *Ponte Verdra, FL:* **Georgia Thoracic Society.** (Tri-State with South Carolina and Florida). Contact Dan Groves, American Lung Association, 2452 Spring St., Smyrna 30080. PH: 404/434-5864.

8 — *Atlanta:* **Congestive Heart Failure.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-13 — *Atlanta:* **Interventional Radiology for Technologists & Nurses.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-14 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

16-18 — *Sea Island:* **Georgia Urological Association.** Contact Dr. T. S. Trulock, Albany Urology, 1950 Palmyra Road, Albany 31701. PH: 912/883-1503.

17-19 — *Atlanta:* **Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXIV.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-22 — *Sea Island:* **Georgia Surgical Society.** Category 1 credit. Contact William McGarity, M.D., Emory Clinic, 1365 Clifton Road, Atlanta 30322. PH: 404/321-0111.

21-23 — *Pine Mountain:* **Georgia Chapter, American College of Physicians.** Contact Robert Copeland, M.D., 1550 Doctors Dr., Ste. 301, LaGrange 30240. PH: 404/884-2641.

23-27 — *Sea Island:* **Georgia Obstetrical & Gynecological Society.** Category 1 credit. Contact Chester Lane, 69 Butler Street, SE Atlanta 30303. PH: 404/659-0289.

24-25 — *Atlanta:* **Quantitative Thallium Myocardial Tomography.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

24-28 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-28 — *Savannah:* **14th Annual Neonatology — The Sick Newborn.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

27-29 — *Hilton Head Island, SC:* **Current Financial Strategies — Your Investments.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

28 — *Atlanta:* **Recent Advanced in Clinical Oncology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-39 — *Augusta:* **Advanced Trauma Life Support.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

OCTOBER

1-5 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3 — *Augusta:* **Psychiatry Clinical Interface.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

4-5 — *Amelia Island, FL:* **Third Annual Conference on Critical Care.** Category 1 credit and AAFP Prescribed credits. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

4-5 — *Atlanta:* **Reproductive Health Care.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5 — *Augusta:* **Pain Management.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

5-6 — *Amelia Island, FL:* **Third Annual Symposium on Critical Care.** Category 1 credit. Contact Penny Ballard, Office of CME, Medical Center of Central Ga., 777 Hemlock, Box 1005, Macon 31208. PH: 912/744-1634.

11-14 — *Sea Island:* **Georgia Society of Orthopaedics.** Category 1 credit. Contact Nell Hurt, 105 Collier Road, Ste. 5000, Atlanta 30309. PH: 404/355-0743.

12-14 — *Atlanta:* **Gastroenterology for Primary Physicians.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

18-19 — *Atlanta:* **Neurotrauma Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

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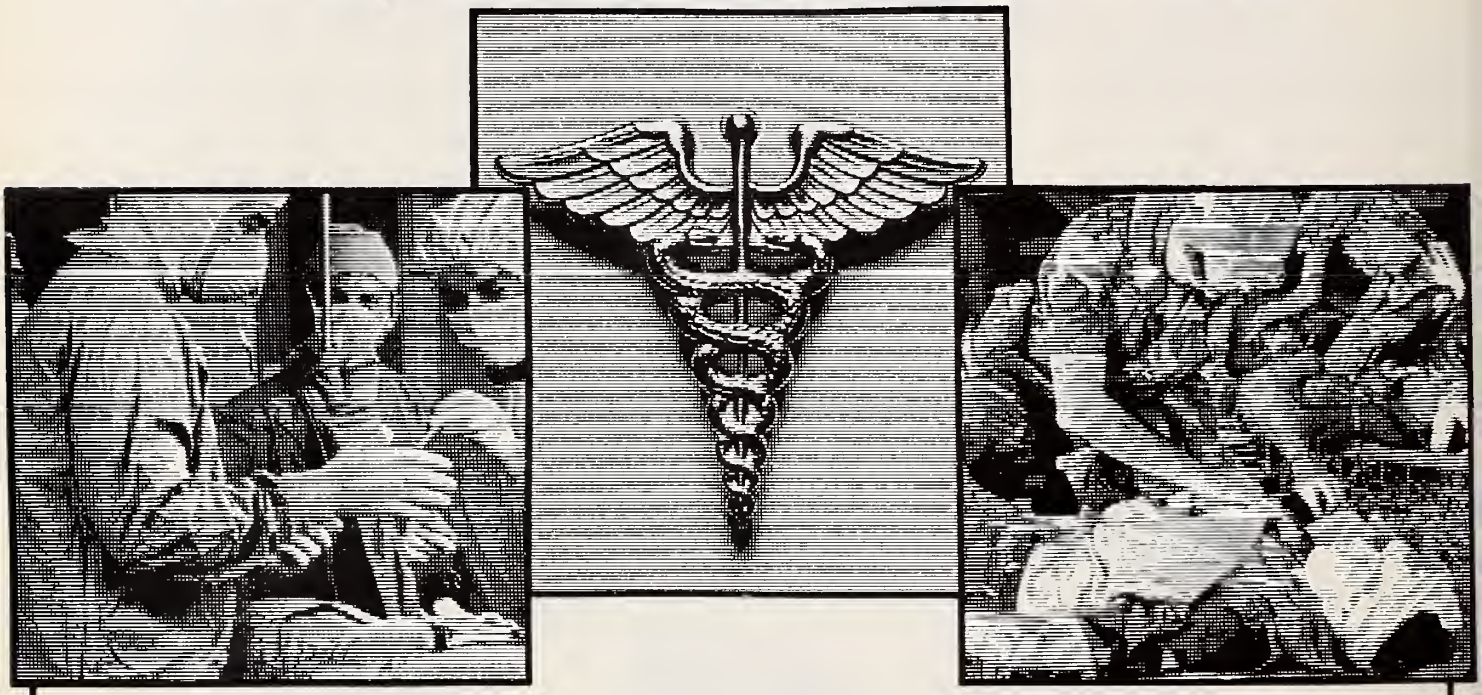

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The Hospital/Physician Relationship: A Look at Some Fundamentals

Edward J. Fechtel

THE NEED for hospitals and physicians to work closely together is readily perceived after a review of the fundamentals of the hospital-physician relationship. It begins with an examination of the complex health care delivery environment today. We have every reason to be concerned about the increasing criticism and pressure to bring about radical changes in one of the greatest health care systems in the world — one that has been responsible for great scientific advances in health care and which endeavors to provide access to high quality care for all citizens. Rather than receiving praise and compliments, however, we are bombarded with complaints about accelerating health care costs, struggles to get adequate payment, and keeping pace with technology. We have thus become preoccupied with defending our actions.

Deliver high quality care but do not increase the cost is the essence of the mandate we are being given by business, third-party payors, and the government. A growing number of people believe that somehow an adaptation of the Canadian health care system or a shift to national health care insurance will guarantee adequate, quality health care delivered with costs held in check.

We have every reason to be concerned about the increasing criticism and pressure to bring about radical changes in one of the greatest health care systems in the world.

Since the 1950s, the hospitals have been accustomed to proliferating Joint Commission standards, federal and state regulations, and Medicare Conditions of Participation, increasing restraints on reimbursement and the imposition of limitations on autonomy in hospitals. Indeed, the practice of medicine and the professional judgment of physicians is being increasingly challenged with the emergence of peer review organizations, managed care programs, and the like. It is now becoming apparent to physicians what has been known to hospitals for some time: there is increasing encroachment on the autonomy on all health care providers, and it is very disturbing. As we seek to overcome our frustration, we should take a moment to recall the fundamentals upon which our health care system has been built rather than listen to the negative rhetoric regarding the provision of health care and its future.

Mr. Fechtel is Administrator, St. Mary's Hospital, 1230 Baxter St., Athens, GA 30613.

The first fundamental is that what we have to offer fulfills a basic need of humanity — health care. We function in a highly civilized society in which the fundamental right to have open access to health care is widely accepted. Hospitals and their medical staffs have been and remain committed to that access. Nobody is going to come up with a better answer than a hospital and its medical staff to provide quality health care. The pressing problem is how to refocus everyone on that simple fact. A society such as ours cannot allow impairment of a sys-

tem built to deliver quality health care and risk drifting into mediocrity.

Another of the fundamentals is the interdependence of the hospital and the physicians on its medical staff. The physician will continue to be the central figure in institutional health care. Nothing happens in a hospital without the physician. No patients are admitted. No services are performed. Dependence upon the physician to make things go is both paramount and supreme. The hospital relies upon its physicians, who have the education, training, and statutory authority to order treatments, prescribe medications, and so forth. On the other hand, the physician relies upon the hospital, which has the facilities and personnel, for high quality services, convenience of his professional practice, adequate resources to diagnose and treat patients including up-to-date equipment, and a measure of continuing education. It is the hospital that must assure that prescribed services are readily available and promptly carried out by the hospital's staff to the extent desired by the physician.

Over the past 25 years, this interaction between the physican and the hospital has been changing; however, it still remains a very delicate and intricate dependency of both the institution and the physician upon one another. This dependence and the way in which it is handled in the future is crucial to the continued effectiveness and efficiency of quality health care delivery in the institutional setting.

This interdependence is not altered in any significant way by the appearance of the nonphysician health care professionals who are seeking a greater role in determining the health care services to be delivered to the patient in the hospital. The institution should and will still rely upon the physician, not only to examine the credentials of such health care professionals but also to establish guidelines and rules as to how they will function, to monitor the quality of their service and the like.

A society such as ours cannot allow impairment of a system built to deliver quality health care and risk drifting into mediocrity.

Given all of the above, we must learn to better tolerate the stresses and strains being placed on this interdependence of hospitals and physicians. Hospital admissions and patient days of service are in a downward trend, which exacerbates the problem for the hospital endeavoring to provide the resources desired by attending physicians while at the same time maintaining financial viability. To offset this, greater emphasis is being placed on maintaining present volume of services by increasing market share, additional revenue increasing activities, and competitive efforts among hospitals directed at attaining and maintaining physician loyalty. Moreover, there is some competition from physicians in traditional services provided in the hospital setting which may increase as the trend toward ambulatory services and home care grows. Quite frankly, no easy answers to this exist. But we owe it to ourselves to keep searching for a solution.

I hope this brief article supports the conclusion that hospitals and physicians more than ever need to form an effective coalition. That is certainly my perspective. There are many things hospitals and physicians have in common — the healing arts, public expectations of quality care delivered without error, and government oversight or loss of autonomy. Also, we are asked to accept a growing underinsured patient base and satisfy individuals and groups who want no further escalation, and who demand a decrease, in health care costs regardless of the reason or impact. Revisiting the fundamentals I believe is also the path to revitalizing our optimism and providing a framework that will enable us to rebuke our critics and retard erosion of confidence in our health care system.

Testimony on Rural Hospitals

Gary Dolack

(In December, 1989, Senator Edward M. Kennedy visited Hancock Memorial Hospital in Sparta, Georgia, as part of a week-long nationwide tour to examine health care problems in America. The tour was an effort to achieve what Kennedy terms "fundamental and comprehensive reforms in all aspects of the health care system," and it focused on four areas: the uninsured, long-term health care, rising costs of health care, and the collapse of essential health care facilities.

At the hearing in Sparta, Senator Kennedy and Georgia Congressman Roy Rowland heard testimony on a number of rural health care problems. One of those presenting testimony was Mr. Gary Dolack, Administrator of Hancock Memorial Hospital. His remarks are presented in the following article.)

Nearly 1 million of the nation's uninsured live in Georgia. They represent 17.7% of the total population.

MR. CHAIRMAN, . . . I am pleased to have the opportunity to be here today to share with you some of my thoughts and perceptions on access to health care services in rural Georgia. Your presence in Sparta today highlights the access problems that exist in our community.

Although today's hearing is being conducted in Sparta, Georgia, a small, economically depressed rural community in the heart of the South, what you hear today can be extrapolated as applying to other areas as well. Rural hospitals throughout this nation are in trouble. If our rural hospitals were the patient, our doctor would describe our condition as critical, and the prospects of survival would be very grave.

When we discuss issues such as health care, we tend to get caught up in technical jargon — in facts and figures. And while I will share with you facts and figures, that is not what this hearing is about. We must not forget that discussions of health care are about real people and their right to access affordable, high-quality health care.

Mr. Dolack is Administrator of Hancock Memorial Hospital, P.O. Box 490, Sparta, GA.

Nationally, 37 million are medically uninsured, millions more are underinsured, and the number of medically indigent grows every year. We see the same type of trend here in Georgia. Nearly one million of the nation's uninsured live in this state. They represent 17.7% of the total population. The percentages of uninsured rise when study focuses on the young, racial minorities, inner city and rural residents. For example, 20% of rural Georgians are uninsured. More than one half (55.2%) of the working people between 50% and 100% of federal poverty have no insurance. What is most surprising is that 75.6% of Georgia's uninsured come from working families (721,572 of 954,366).[1]

A recent survey of 1600 Atlanta employers revealed that ⅓ did not provide health insurance to their full-time employees. While 70% of these employers expressed an interest in adding insurance, it is unlikely that they would be willing or able to provide the broad range of benefits that Georgia insurance law requires.[2] The problem in Sparta tracks this state and national trend.

Although the uninsured do receive care, they tend to seek too little care too late. They come to us

Participating in a hearing in Sparta, Georgia, as part of a nationwide tour to examine health care problems in the United States are (L to R): U.S. Representative J. Roy Rowland, Georgia; Ted Holloway, M.D., Gary A. Dolack, Administrator, Hancock Memorial Hospital, Sparta; and U.S. Senator Ted Kennedy, Massachusetts.

to deliver their babies, but not to receive prenatal care. They come to emergency rooms with serious illnesses that could have been treated less expensively a year sooner. Because of a lack of care, we in rural areas see outcomes one would find very rarely in urban locations. On three occasions, we have seen diabetic patients for follow-up after a lower leg amputation. When the dressings were removed, their wounds were full of maggots. With proper care, this would not have happened. Patients also come to us after they have depleted their few economic resources to pay for care, thereby assuring that they will have no resources to recover from the financial devastation of illness.

Much of the rise in the number of uninsured has been caused by the recent deterioration of Medicaid coverage. The problems of Medicaid are more than just eligibility. Many people who are eligible are not enrolled. Over one weekend at Grady Hospital, in Atlanta, nearly 80% of the mothers who came for a delivery had not seen a physician during their pregnancy. They all proved to be eligible for Medicaid but weren't enrolled. These facts show a need for greater outreach, but non-enrollment by eligibles also comes from the 16-page form that can't be completed in one visit to an eligibility worker. We need a simpler form, an end to overly complicated resource tests, and eligibility workers located in hospitals and clinics where the patients are. Enrollment won't happen if it takes three appointments and six cab rides to do the paper work.

Medicaid enrollment won't happen if it takes three appointments and six cab rides to complete the paper work.

Another problem deals with the loss of health insurance. While the

U.S. health system is currently built on employer-provided insurance, that link is slowly breaking down. The change from a manufacturing to a service economy is certainly taking its toll. In addition, from a rural perspective, where many individuals are self-employed, current federal law discriminates against these individuals in that they are only able to deduct 25 percent of their health care premiums as a business expense. Individuals with chronic-illness can't get insurance at any price.

Here is one dramatic example. The parents of Christopher House (age 5) owned a small business and covered their family with a group plan. When Chris was diagnosed as having leukemia, the premium jumped 1,300 percent to $23,000 a year. That didn't seem much like insurance, and the family now numbers with the uninsured. Under these circumstances, the half million Georgians covered under small group plans don't have much that looks like insurance.

Thus far, hospitals have been able to serve as a safety net for many of the uninsured. But I am concerned that hospitals — particularly rural hospitals — are going to find it ever more difficult to maintain this position in the future.

Of course, I'm talking about the under-funding of Medicare and Medicaid. Ray Brees, Chief Executive Officer of Paulding Memorial Medical Center, and Chairman of the Georgia Hospital Association's Council on Smaller Hospitals just two weeks ago authored an article that appeared in the *Atlanta Journal and Constitution*. . . . Mr. Brees makes several good points that all of us who attempt to deliver health care services in a rural setting are experiencing. For example, we are experiencing ever increasing costs due to new technology and shortages in the health care labor pool, pushing costs beyond our control. In addition, we find our patient mix changing. With the out-migration of our young people, our patients tend to be older and more seriously ill. Further, more of our patients are dependent upon Medicare and Medicaid as the principle payers. It is not uncommon for a rural hospital here to have 70% of its patients covered under the two programs. Under these circumstances, cost shifting doesn't work.

A large part of the rural hospital problem is the undersupply of physicians in rural areas. I commend to you and your staff an article by Dr. Alan Dever, et al published in the August, 1989 issue of the *Journal of the Medical Association of Georgia*. According to this article, there should be 191 physicians for every 100,000 people.[3] Georgia as a whole has 148 per 100,000 people, but counties with less than 20,000 residents have less than 50 per 100,000 population. The success of a rural hospital is at least 50% dependent on recruitment of physicians. Our hospital would not be open today without Dr. George Green's solid commitment to this institution. Once a physician gets caught by the hearts of rural people they will likely stay for the long haul.

I would be remiss in my duty if I didn't talk about reimbursement problems, because I believe the issue of adequate reimbursement is bound firmly to the issue of access. Unless reimbursement is addressed, we won't be here in 5 years.

Closings are not the only evil result from shrinking reimbursements. Many hospitals will attempt to survive by emphasizing only the parts of their operation which pay the costs. This stimulates a rush to new technology.

. . . One in every four dollars in hospital charges is not collected due to indigent care or Medicare/Medicaid write offs.

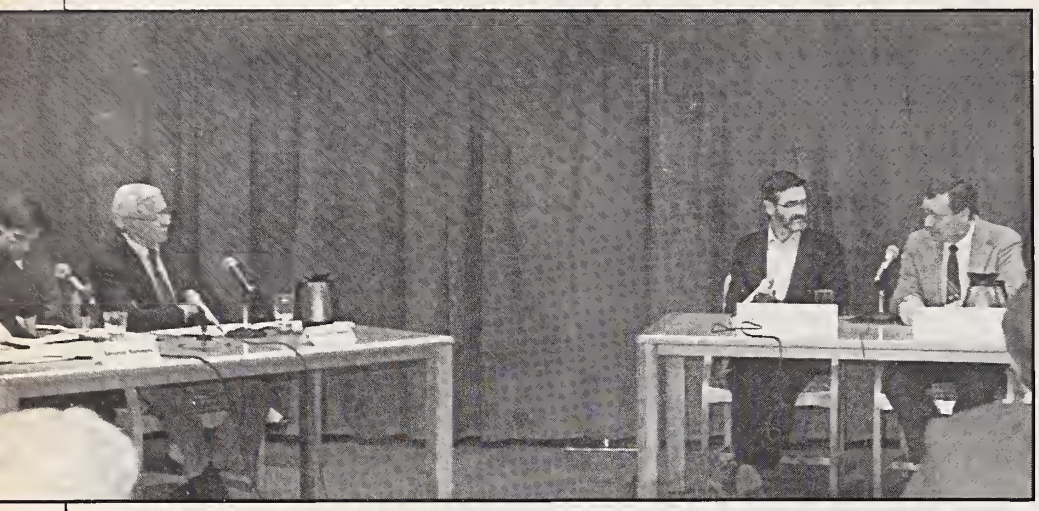
Hancock Memorial Hospital provides care to many who cannot afford to pay for that care. They have no coverage under Medicare, Medicaid, an employer sponsored group health plan, or a private insurance policy. Last year, we provided more than $300,000 worth of care for which we were not paid. Fortunately, Hancock County stepped in to assist with its subsidy. Most other hospitals do not have such backing.

If Hancock Memorial Hospital were put on wheels and moved 50 miles in almost any direction, our rate of payment under the Medicare program would be increased markedly. After the Health Care Financing Administration applies all the factors to arrive at what hospitals are paid under Medicare, Atlanta-area hospitals receive 43% more for the same care to the same patient. If Hancock Memorial were paid the Atlanta rates, our tax burden would be greatly reduced, if not eliminated.

Hancock Memorial is not alone. Rural hospitals in Georgia expect to receive $26 million less than their costs for treating Medicare enrollees during 1989.

Last year Congress acted to reduce this unjustified payment gap, and we are truly grateful. Hopefully, Congress will continue to address this vital issue. During the past 6 months, Hancock Memorial has incurred $885,000 in charges for services to Medicare enrollees. Medicare paid the hospital $477,000 or less than 54 cents on the dollar. Federal regulations forbid the hospital from charging the patients for this difference. In fact, the patient is led to believe that their bills are paid in full.

The Georgia Hospital Association sponsored three studies complated by independent accounting



Senator Kennedy and Congressman Rowland listen to testimony from Dr. Holloway and Mr. Dolack about the problems facing rural hospitals in Georgia.

firms. Each was based on reimbursements compared to audited cost reports.

1. The first study based on 1987 data showed that Georgia hospitals had a 5% net on Medicare business in 1986. According to the study's projections, this profit has turned to a 5.86% loss in 1989. The loss rate for rural hospitals is 9.67%. That is a statewide reimbursement which is $60 million less than what it costs to provide service.
2. A similar study of Georgia Medicaid pegged the loss at 14%. The rate for small hospitals was 17.05%.
3. Ernst and Whinney studied the 1988 financial statements of 22 hospitals in Congressman Ed Jenkins' district and projected they would lose $29 million on Medicare in 1990.

Hancock county is unique, however, in that all these problems forced the closure of our hospital in the mid 1970s. For 10 years, the citizens were compelled to face life without ready access to hospital care. The people wanted their hospital back so badly, however, that they pledged their property taxes to guarantee its operation. In 1985, Hancock Memorial reopened; but, at the cost of a heavy tax burden. Last year, one third of the county's expenditures went to support the hospital. This year, we hope to cut this burden in half. Still, the funds required will place a hardship on our taxpayers.

One of the ways we hope to ease our financial strain is by working even closer with the community primary health center. Now that their new physician is on board, I foresee working together for the benefit of both facilities. Through a sound, cooperative effort, we can provide more ready access to our citizens.

I would say that Hancock Memorial Hospital and the people of Hancock County are in some ways the lucky ones. We recognized a need, and we responded in an overwhelming fashion to ensure continued access to high-quality health care in this county. But other rural and urban communities may not be so lucky.

The closing of our hospital is not a unique experience to Georgia. In the past 2 years, 160 rural hospitals nationwide have closed their doors. Three of these were in rural communities in Georgia. Residents of Clay, Heard, and Turner counties must now search elswhere for hospital care. When a community's hospital stops operating, child health care suffers, health care for the chronically ill deteriorates, and access to health care is severely restricted. The Georgia Hospital Association staff and a legislative committee are today in Bleckley County where the hospital board expects to lock the doors by Christmas day. In 1987, 41 of Georgia's 106 rural hospitals operated in the red. Without some significant change in their financial picture, many of these institutions will not be here 5 years from now.

Closings are not the only evil result from shrinking reimbursements. Many hospitals will attempt to survive by emphasizing only the parts of their operation which pay the costs. This stimulates a rush to new technology. They will close emergency rooms and discontinue obstetrical services. Nobody wants to expand an Emergency Medical Services despite its inadequacy. One startling example of a cut in service occurred this fall in Phoenix City, Alabama, just across the Chattahoochee from Columbus, Georgia. The hospital in Phoenix City stopped delivering babies. You can now draw an arc with a 100 mile radius around that city and within that area find no obstetrical program in Alabama. The burden now falls on Columbis hospitals for the obstetrical care for this large section of Alabama.

We are far from being out of the woods here in Hancock County. But if anything, we know the problems and certainly some of the solutions. Certainly, the federal and state government must do their part to ensure adequate reimbursement for services under the Medicare and Medicaid programs. To pay below

cost for health care services for the elderly and poor — services that represent over 50 percent of a hospital's business — will only hasten the demise of health care delivered in hospitals of this state.

Likewise, I would urge Congress to seek solutions to the problems of the uninsured. I have no magic solution for this problem, but the fact that 37 million Americans are without health insurance is a national disgrace, and I believe we should all work toward a solution to this growing problem.

There needs to be real insurance that covers the family of Chris House. If the private sector can't provide affordable insurance products, the state and federal government must step forward and do the job. Senator, I commend you for your introduction of a mandated coverage bill. This approach when combined with incentives to create affordable insurance products for small employers provides some hope for those who struggle daily to keep a patch work system together.

It is not uncommon for a rural hospital here to have 70% of its patients covered under Medicare and Medicaid. Under these circumstances, cost shifting doesn't work.

We must patch the holes in our health care safety net. Failing to do so will force more rural hospitals to downsize their services or close, thus further eroding our rural residents ability to receive access to the quality health care they need and deserve.

Rural hospitals throughout this nation are striving valiantly to fulfill our mission of providing the highest possible quality of care to our patients; but, we need relief. If health care is a right to be readily available to all and not just a privilege of the few, then a means to adequately finance that health care — that right — should be found.

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Hospitals Pay Dearly For Government Underfunding

Damon D. King, F.A.C.H.E.

INCREASINGLY HIGHER health care costs, skyrocketing health insurance premiums, the devastation of small and rural hospitals, and the collapse of our country's entire hospital system could be the sad price we pay for the consistent and rapidly mounting underfunding of local, state, and federal programs, such as Medicare. Last year, The Medical Center of Central Georgia underwrote these government programs to the tune of $57,746,157 — which comprised 28 percent of our total operating budget.

Each year, a greater number of our patients are older, sicker, and less able to pay for their medical care. In the past three years alone, The Medical Center's volume of Medicare business increased 43 percent. But while Medicare business has increased, reimbursement from the federal government has decreased, covering a smaller portion of Medicare charges each year. Last year, we were reimbursed 57 cents for every dollar of Medicare services rendered, a figure which is high compared to national averages. In addition, payments have also failed to keep pace with inflation. The cost of goods and services hospitals purchase has risen about twice as fast as Medicare reimbursement rates.

Cost-shifting has a very strong trickle-down effect and is one of the primary reasons our health insurance premiums are going up at a rate of 20-40 percent a year.

Underfunding Affects Patients, Businesses, and Communities

Hospitals fortunate enough to have a strong private pay patient-base have managed to remain healthy. How? We have been forced to raise prices, shifting the cost of these underfunded government programs to those patients. This, combined with a total resources management program, has allowed us to maintain a reasonable bottom-line.

Cost-shifting has a very strong trickle-down effect and is one of the primary reasons our health insurance premiums are going up at a rate of 20 to 40 percent a year. In essence, Congress and the Administration have found a way to tax the half of us who are still paying for our health services through health insurance or out of our pockets without calling it a tax. And when a politician at any level finds a way to do this, we're in great difficulty. This has been happening at an alarming rate at the federal level for the last five years. The Medical Center's underwriting of the program increased from $5 million to $30 million in that period of time. It's frightening to contemplate what's next.

Mr. King is President of The Medical Center of Central Georgia, 777 Hemlock St., P.O. Box 6000, Macon, GA 31208.

Community Hospitals Are At Risk

For the many small and rural hospitals that do not have a sufficient number of private pay patients, cost-shifting is not an option. What have they done? They have suffered. They have consumed their assets, have not been able to replace or purchase new equipment and technology, and have not been able to modernize their plants. For these hospitals, it's not just a matter of being successful, it's a matter of survival.

And should they fail in the daily struggle to keep their doors open, a greater, more serious problem is created. Access to health care for those who depend on them, especially the elderly and indigent, is severely decreased. These are the very people for which Medicare was intended to help.

Underfunding Threatens To Destroy Our Hospital System

Unless something is done, and done soon, the country's entire hospital system as we know it will collapse. Most of the major teaching hospitals in America are in severe financial shape. One such facility, one of the premier teaching hospitals in the South for almost 100 years, was a healthy, 1050-bed hospital just five years ago. Today, its bed capacity has been reduced to 450, it is bankrupt, and the Joint Commission on Accreditation of Healthcare Organizations recently revoked its accreditation.

This is not an isolated case. Others are in trouble, as well. Let it happen to 20 to 25 of our major teaching hospitals and in 10 to 20 years we will experience a severe shortage of physicians and health care professionals. And it will take us another 20 years to recover.

Large teaching hospitals, like small and rural hospitals, are most vulnerable to underfunding of government programs. Unable to shift costs because the majority of their patients are indigent, they must absorb those unreimbursed charges. How long can this realistically go on?

Last year, we were reimbursed 57 cents for every dollar of Medicare services rendered, a figure which is high compared to national averages.

What Went Wrong

One of the greatest inequities in all this is that not nearly all of our unreimbursed costs are going to fund indigent care. When the Medicare program was formulated, it was based on demographics of the 1930s, 40s and 50s. People who retired then did not have much, if anything, which is why programs such as Social Security were created.

Those demographics, however, have done a complete flip-flop, and people 65 years of age and older control over two-thirds of the wealth in this country. Seventy-five to 85 percent of them do not need this massive subsidy — 1.25 million of them are millionaires or multi-millionaires. Although these Medicare patients today can afford their own supplemental insurance to pay what Medicare doesn't, they receive this huge subsidy at the expense of our private pay patients. Medicare patients, some of whom are the richest people in town, come to our hospitals, receive services and go on their merry way, with the private paying patients footing half their bill.

Some Solutions

The simplest solution to program underfunding is for the government to allow hospitals to bill the patient for the balance of their bill Medicare did not cover, or have the program based on a means test to determine who is eligible for coverage, with the government paying the full bill of those who are eligible. Only those who can demonstrate need would benefit.

The Outlook

Unfortunately, I do not foresee Medicare reimbursement rates improving in the near future. Congress just hasn't got the guts to face the issue and do something to fix or at least alleviate the problem.

If Congress let Medicare recipients know the program is at risk of collapsing, there would be a tremendous lobbying effort and something would be done. But Congress has put up a smokescreen on this issue and has protected the recipient against any penalty. They know hospitals will pass this cost onto their private pay patients. So hospitals are penalized, while those who benefit from the program are shielded from the problem, oblivious to the inevitable.

When confronting the problem of program underfunding, however, one thing is certain. If the federal government doesn't reverse itself in these funding cuts for Medicare or allow hospitals to take some action, such as balance billing the patient, our system will collapse. There's no doubt about it.

Some Hope

Although there seems to be no end in sight to the Medicare crisis, a new Indigent Care Trust Fund has been implemented in conjunction with Georgia's Medicaid program. The program allows hospitals that serve a disproportionate share of

low-income patients to make contributions to a fund. Funds contributed by the hospitals are matched almost 2-1 by federal dollars then returned to the hospitals in the form of greatly enhanced Medicaid funding. This trust fund is a crucial step in relieving the unfair burden of funding indigent care.

The Medical Center can expect to receive an estimated $4 million annually as a result of this trust fund, enhancing our Medicaid reimbursement by approximately 29 percent. We are passing all of this onto our private pay patients by reducing prices on inpatient services 5 percent. We have been shifting this load to them, and now we have an opportunity to "unshift."

We believe this across-the-board price roll-back is unprecedented. We want to send a clear message with it that if, for instance, the federal government would fund Medicare appropriately we could reduce our prices 10 to 15 percent.

Although there seems to be no end in sight to the Medicare crisis, a new Indigent Care Trust Fund has been implemented in conjunction with Georgia's Medicaid program. This trust fund is a crucial step in relieving the unfair burden of funding indigent care.

Of course, many hospitals that are eligible to participate in this program will not be in a position to roll back prices. They simply have not had sufficient private pay patients to do the massive cost-shifting and have literally been hanging on by their fingernails. What it will mean for them, however, is that they will be a little healthier. Maybe they can purchase much needed equipment and technology and modernize their plants — things that have been sorely neglected because of severe underfunding. For some hospitals, this improved reimbursement may mean an extension of their lives.

It is essential this program stay in place and Medicare funding be returned to reasonable levels if our health care system, as we know it, is to remain in existence.

The Rising Cost of Health Care: Who Will Pay the Bills?

T. Marshall Hahn, Jr., Ph.D.

I APPRECIATE this opportunity to offer some brief comments on the corporate perspective on the critical subject of rising health care costs. This challenging topic involves each of us here today and will continue to affect every member of our society in the coming years.

With the year 2000 just around the corner, a quick look at the future of health care costs paints an alarming picture. For instance, it is estimated that a typical visit to a doctor's office at the turn of the century will cost $82, more than twice last year's cost of the same visit. This one element will greatly inflate the already bloated health care tag. In the year 2000, the national health care expenditure is projected at a staggering $1.5 trillion, representing 15% of our gross national product. By the year 2010, hospital costs are anticipated to reach an overwhelming $4,000 to $5,000 per day.

Undeniably, these costs will have a disruptive effect on American corporations. A 1986 Mercer-Meidinger study shows that, if unchecked, increases in corporate health care expenses by 1994 could eliminate all profits for the average Fortune 500 company and the largest 250 nonindustrials. As corporations across the country struggle to remain competitive in an increasingly difficult global marketplace, containing these costs has become a priority.

The issue . . . is accountability. With employees remaining unaware of actual costs, they have not been discouraged from using expensive services, sometimes unnecessarily.

These escalating health care expenses also affect physicians, hospitals, and American consumers. Health care is one of the primary sources of inflation in the cost of goods and services. Ultimately, everyone will be affected. As bleak as that scenario sounds, it is a highly probable one given the current situation. I know you are all familiar with the figures and the statistics, but we need to remind ourselves what a dangerous situation we are facing already.

The United States operates the most expensive medical system in the world. It is 50 percent costlier than Canada's and twice as costly as Japan's. As I mentioned earlier, America will be unable to compete effectively in the international marketplace if we remain burdened with this bill.

Our nation's health care industry is larger than our defense budget . . . and it is growing more rapidly than the computer industry. While the general inflation rate rose 4 percent in 1989, medical insurance costs increased by 19 percent.

Medical inflation has averaged approximately three times the general inflation rate over the past 5 years. That trend does not appear to be reversing. In 1989, our na-

Dr. Hahn is Chairman and Chief Executive Officer of Georgia-Pacific Corporation. Send reprint requests to him at P.O. Box 105605, Atlanta, GA 30348.

tional health care bill amounted to $542 billion, close to 12 percent of our GNP. This represents the largest share of the GNP among all industrialized nations that do not offer a form of national health care.

Our nation's health care industry is larger than our defense budget . . . and it is growing more rapidly than the computer industry.

Let me relate some of these costs to a company I know very well, Georgia-Pacific. Georgia-Pacific covers 42,000 active employees under its health plan. Including retirees and dependents, we insure more than 100,000 individuals. In 1989, Georgia-Pacific's health care bill exceeded $100 million. Health care is the costliest item on our benefits side, amounting to 10 percent of our payroll costs. The cost of Georgia-Pacific's medical benefits has grown by 80 percent in the past 5 years, and jumped 22 percent in 1988 alone.

To combat the rising cost of this benefit, Georgia-Pacific has implemented programs in the past 5 years similar to those adopted by other major corporations. For instance, we initially encouraged outpatient surgery, which now is no longer cost effective due to its own sharp increases in cost. We offered HMOs, which also are not proving to be cost effective. We implemented precertification programs that include obtaining second opinions prior to having surgery. The savings for this element are doubtful.

Georgia-Pacific also eliminated its prescription card program since we found that some employees, unaware and unconcerned about the high cost of medication, sometimes abused this program.

Health care is indeed becoming an expensive item for everyone. Employees will notice larger chunks coming out of their paychecks in higher deductibles and co-payments. Employers realize that healthcare costs are consuming a significant portion of operating profits.

There obviously is no easy answer to this escalating problem. Costs cannot be contained solely by implementing cost management strategies within individual companies. Tinkering with isolated components of the existing system also will offer no permanent solution. Instead, we need to adopt widespread reform — national in scope — that involves everyone in the public and private sector — from government and industry to the health profession and individual consumers.

Our goal at Georgia-Pacific is to continue providing our employees and their famiies with health care protection, while keeping costs down. Nationally, our objective for the 1990s should be to provide adequate health care for all Americans — not only for employees of large and small companies, but also for the almost 37 million Americans who are presently uninsured. To accomplish this, we must find a way to contain runaway costs — instead of merely shifting rapidly escalating costs from one group to another.

While employers want health care expenses to stop consuming so much of their corporations' operating profit, we realize that hospital administrators have similar goals as they strive to maintain high-quality patient care and hospitals' profit. Responsibility for a solution lies not with one sector or the other, but rather with each component — government, health care providers, insurance carriers, employers, and employees — exercising greater reason in providing and using medical services.

We must change outdated notions about our expectations of a health care system.

Since health care essentially begins with a doctor and patient, that would appear a logical place for reform to begin. While most of the medical services provided to Americans are necessary and greatly enhance our nation's health, there also appears to be significant waste in the system. According to the Mercer-Meidinger study, up to 30 percent of medical tests and procedures performed are unnecessary or add marginally to medical information already known. In addition, government estimates report that abuse accounted for nearly 10 percent of the nation's 1988 Medicare bill.

It is obvious that the surge in malpractice suits resulting in exorbitant insurance premiums plays a leading role in forcing doctors to practice defensive medicine. We cannot all continue, however, to pay this price. If we can accomplish reform in malpractice claims — a measure which I advocate — doctors must respond by performing only basic tests and procedures necessary to contribute to the well-being of the patient.

Related examples are the expensive technologies and medications that are widely available. While advances in technology are applauded and access has largely contributed to promoting the quality of life, physicians must strive to use these expensive items judiciously.

Another area in which costs must be controlled is that of outpatient services. Care given in this area was once relatively inexpensive. However, with hospital costs controlled to a greater degree by government, outpatient services are being used more often and expenses are some-

times inflated to offset inpatient revenue deficits — thus, increasing overall cost.

Physicians must work with hospitals and insurance carriers to set standards for the appropriateness and value of providing health care to the public. If this collaboration is not undertaken quickly and voluntarily, we may expect the government to step in and impose its own standards. In fact, with the advent of government imposing ceilings on Medicare costs and hospital services, Congress' attention has been increasingly focused on the health care issue.

The cost of Georgia-Pacific's medical benefits has grown by 80 percent in the past 5 years and jumped 22 percent in 1988 alone.

I acknowledge there are also many reasons why hospital costs continue to rise, including the purchase of expensive, up-to-date technology, and the failure of Medicare to keep pace with medical inflation. We cannot afford, however, to weaken our ardent efforts to restrict costs. For instance, hospitals should consider avoiding the purchase of extremely expensive technology when it may not be justified by the level of demand or if the equipment could be shared among other local hospitals.

Various predictions about the future of hospitals include the consolidation or regionalization of hospitals, and greater specialization so that not all hospitals will provide every service to all patients. And a system of rationing — such as exists in Oregon, where priorities are set for operations and patients to receive treatment — perhaps will expand in other states.

Various predictions about the future of hospitals include the consolidation or regionalization of hospitals, and greater specialization so that not all hospitals will provide every service to all patients.

Much as other American industries have done, it may also be essential for hospitals to eliminate extra administrative layers, professionals who often command much larger salaries than those individuals needed to perform the medical services.

Our experience at Georgia-Pacific, for example, reflects successful transfer of as much authority and responsibility as possible to those managers who interact daily with staff on the front lines. In my view, it is imperative that your business — the most intimate of service industries — call for lean senior management and empowered middle management.

As I said earlier, the burden of responsibility for these rising costs falls not only on the providers, but also on the consumers. Employees have long considered health care to be a basic right. They undoubtedly will be the most disturbed when the level of health care begins to change, as it inevitably will. Problems have arisen, however, from employees being too insulated from health care expenses, such as I mentioned with Georgia-Pacific's prescription card program. Part of the education process will result from employees having to shoulder more of the financial burden.

The issue, as it so often is, is accountability. With employees remaining unaware of actual costs, they have not been discouraged from using expensive services, sometimes unnecessarily. Although employees may be displeased to see more of these costs coming out of their paychecks for deductibles and co-payments, they must also recognize that employers have been shouldering too much of the cost for too long.

A system of rationing — such as exists in Oregon, where priorities are set for operations and patients to receive treatment — perhaps will expand in other states.

Many companies, which have continued to pay 100 percent of medical costs despite health care's remarkable inflation, will begin having employees pay a portion of these costs. Other companies — Georgia-Pacific, for instance — will increase the deductibles for individuals and families, and for the first time, require employees to contribute toward dependent coverage.

I should again stress, however, that this cost-shifting does not address the primary concern of cost containment. While cost shifting will help alleviate the financial strain

on corporations, we cannot allow it to eradicate our continuing search for broader methods of controlling costs. As an employer, we hope that by shifting a small portion of the health bill to employees, a change might result in the expectations of the health benefit.

Since 53 percent of premature deaths are attributed to poor lifestyle habits, corporations like Georgia-Pacific will continue to offer wellness programs and to offer incentives to healthy employees.

We hope employees will become more prudent in their use of medical services, and begin to think of health insurance in terms of catastrophic care, rather than for common ailments. I am confident no employee would argue that they were not well covered if their insurance plan paid $197,000 of a $200,000 bill.

Employers, I am confident, will continue to pay an equal — if not larger — portion of the health care expense. At the same time, we also will urge greater involvement from our employees, and ask physicians and hospitals to do their part.

Corporations are taking a more active role in communicating the upcoming changes to employees and encouraging them to help control costs by ending the overutilization of medical services and taking better care of themselves. Since 53 percent of premature deaths are attributed to poor lifestyle habits, and healthy employees save the system money, corporations like Georgia-Pacific will continue to offer wellness programs and to offer incentives to healthy employees.

Physicians must work with hospitals and insurance carriers to set standards for the appropriateness and value of providing health care to the public.

With help from government agencies and the medical field, corporations need procedures for measuring the quality of care as it relates to value. We need to develop a realistic measurement of quality control to help reduce the cost of hospital treatment without compromising our employees' health.

Our legal system can play an enormous part in this dilemma as well. Skyrocketing malpractice insurance ultimately is reflected in the nation's health care bill. Of course, high malpractice insurance premiums are due in large part to exorbitant jury awards derived from malpractice lawsuits.

As we approach a new century, this clearly is an appropriate time to implement sweeping reforms in health care spending and to adopt more realistic attitudes. While we have not yet exhausted all of our options to curb spiraling costs, with the current situation already at dangerous proportions, this may be America's last opportunity to reform before being forced to a national system of health insurance.

Because health care costs affect many different sectors with a variety of needs and concerns, we must work together to create proactive, viable, and long-term solutions. We must accept that we may be asked to relinquish certain privileges or accept initially unfavorable situations. We must change outdated notions about our expectations of a health care system.

Who will pay the bills? No one can expect to be insulated from the costs and sacrifices that are inevitable to support health care systems of the future. I have not offered a magic pill to solve the health care dilemma, but it is this kind of dialogue that will enable us to develop a stronger and more balanced health care system that will not only promote good health, but also will take us into the new century in a cost-effective manner.

Hospitals Support Plan to Reduce The Number of Uninsured Georgians

Charles H. Keaton, F.A.C.H.E.

Whether or not a state-subsidized health insurance program would be effective in Georgia depends to a large extent on the source of financing and the cooperation of providers, insurers, and businesses. Georgia's hospitals are willing to address all viable alternatives, including discounted reimbursement, in order to make such a plan work.

HOSPITALS are struggling to make ends meet. That is hardly a startling revelation for anyone involved in the health care system — but the news is worsening. The financial problems of hospitals are jeopardizing the availability of care.

Around the state, hospitals have shut down emergency rooms and stopped delivering babies. While the "brown out" that arises when a hospital eliminates services is less dramatic than a closing, small cutbacks may, nonetheless, have broad implications.

Why are hospitals struggling? Simply stated, government programs no longer pay the cost of providing care to the poor, and private sector payors are resisting the increased charges that are assessed to finance such care. When revenues cease to meet expenses, needed services are lost.

There are a variety of reasons for the financial woes confronting hospitals. The list is familiar to every administrator and hospital CEO in the state: government cutbacks in funding for Medicare; skyrocketing liability insurance rates; and an increasing demand for better, more advanced (and more expensive) technology. Add to those the expectation of a better paid staff; a burdensome amount of paperwork from insurance and utilization review companies, as well as from the government; and the tremendous cost of treating more elderly people and patients with AIDS.

Physicians face the same woes. These problems cripple the bottom line for all providers. Hospitals, however, must contend with an issue that not only is stifling their budgets, but is closing their doors: the burgeoning number of uninsured patients. Hospitals can no longer afford to provide free care to Georgians who have no health insurance.

The Georgia Hospital Association believes it is time for the state to act on its own without waiting for direction or guidance from the national level which may never arrive. Georgia can become a leader in addressing the issue of the uninsured by tackling the problem

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The amount of bad debt reported to the State Health Planning Agency in 1987 totalled more than $235 million for Georgia's acute care community hospitals. Indigent and charity care was approximately $129 million.

head-on. The member hospitals of GHA support the idea of adequate, affordable health insurance for all citizens and believe that state action is necessary to accomplish this goal.

The Problem

In Georgia, a state with a population of 6.4 million, almost 1 million are uninsured.[1] Even more discouraging is that approximately 76 percent of those without insurance are themselves employed or are the dependents of someone who is working.[1] This fact is true nationwide. These people are employed by small firms that cannot afford, or for other business reasons choose not to offer, insurance benefits. Many of them have full-time, minimum wage jobs at fast food restaurants or clothing outlets, or they work part-time jobs that carry no benefits. They make too much to qualify for Medicaid, but not enough to purchase single family coverage insurance. They cannot afford insurance, so many do not have it.

Medicaid in Georgia covers only those citizens whose income for a family of four is 40 percent of the federal poverty standard, or who fall into a special category: (1) pregnant and at 133 percent of the federal poverty level; (2) aged, blind, or disabled; or (3) under age six, with a family income of 133 percent of poverty.[2] In 1986, the working poor between 50 and 100 percent of poverty level composed 54 percent of the total work force in industries unlikely to provide health insurance — retail trade, construction, personal services, entertainment, and recreational services.[1]

The Georgia Hospital Association believes it is time for the state to act on its own without waiting for direction or guidance from the national level which may never arrive.

Uninsured families up to 200 percent of the federal poverty level may not fare any better. Although their income is somewhat higher, they still cannot afford health insurance or the care required for major illnesses, injuries, and obstetrics.

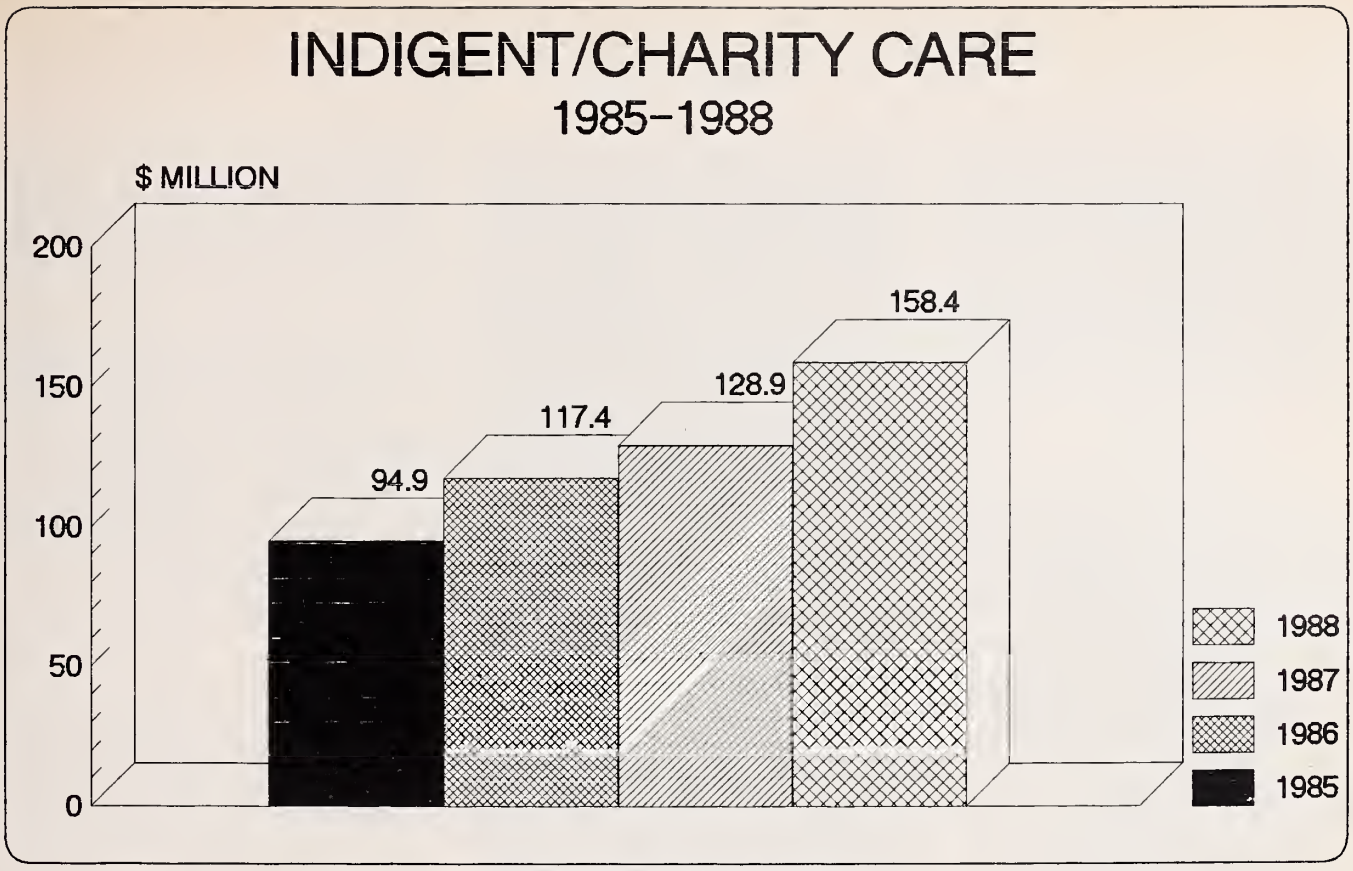
On the other hand, many employees who do have access to insurance coverage cannot afford to pay the necessary premiums. There is a growing trend away from complete health insurance coverage by employers. In 1980, nearly three-quarters of large and medium-sized companies paid the entire cost of individual coverage. In 1988, that figure had dropped to 55 percent.[3] Even large employers are requiring employees to pay part of their premiums, in addition to large deductibles or co-insurance rates.

More than one-third of small employers surveyed in 1987 did not provide employee health benefits.[4] Some are trapped by lower bottom lines and the inability to obtain worthwhile coverage for their employees, since insurers are reluctant to underwrite plans for small or high risk employers.[4]

Until the 1990 Georgia General Assembly passed legislation mandating insurance companies to "group-rate" employers of 50 or less, many small businesses in the state faced single group ratings that could be drastically affected by the claims experience of just one employee. The premium increase resulting from one serious illness or major injury was often more than a small business owner with low overhead costs could afford. The new legislation restricts rate changes for individual groups to no more than 25 percent above or below the experience of the entire group market.

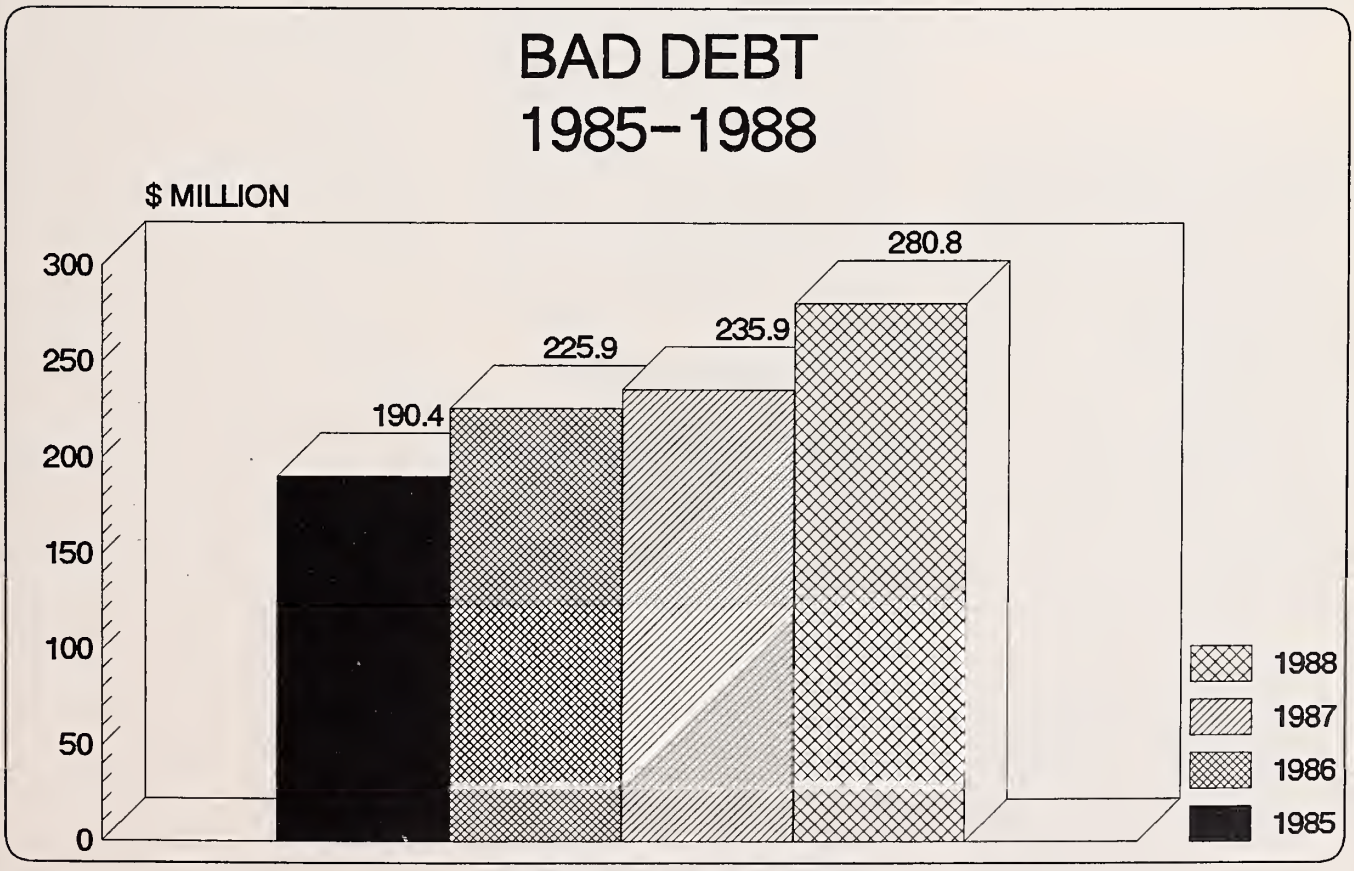
The uninsured generally constitute the sickest patients a hospital sees. Preventive medicine is a luxury they cannot afford, and many of these Georgians are admitted to hospitals critically ill with a disease or infection that could have been easily treated or prevented at the primary care level. Their stays are longer, they require more intensive treatment, and their bills are high. Without health insurance, they have no way to cover the cost of their care. Along with others who are unable to pay, they are classified as either medically indigent, charity recipients, or bad debtors — and hospitals receive no payment for their care.

The amount of bad debt reported to the State Health Planning Agency in 1987 totalled more than $235 million for Georgia's acute care community hospitals (Figures 1 and 2). Indigent and charity care was approximately $129 million.[5] Preliminary data for 1988 indicate even greater losses, including a jump to almost $158 million for indigent/charity care and more than $280.8 million for bad debt.[6]



SOURCE: SHPA ANNUAL SURVEYS

Figure 1



SOURCE: SHPA ANNUAL SURVEYS

Figure 2

Hospitals cannot afford these kinds of losses indefinitely. The administrator of one Atlanta area hospital recently commented that "budget revenues and expenditures were in line until a doubling of bad debt during the current fiscal year . . . We will be in the red because of it . . . ."

State-sponsored health insurance is gaining support across the country. It can be made affordable through subsidized premiums, provider discounts, efficient claims processing, and limits on provider liability.

State and local governments have attempted to help defray the escalating costs of uncompensated care. The Department of Medical Assistance is close to becoming the largest single budget item for the state, with $732 million allocated for Fiscal Year 1991.[7] But while the federal government matches state funds at an approximately 2-1 rate, it also restricts ways in which states can receive and spend money. Georgia's match rate continues to rise, although many of the new dollars fail to produce additional benefits.

In 1987, local governments contributed more than $108 million toward indigent care.[5] Additionally, many counties provide emergency medical services, and all have county health departments which drain their coffers. State and local governments are trying to fulfill their obligations, despite limited dollars and fixed budgets. At the same time, the federal government continues to distance itself from the rising number of indigent and uninsured citizens. A study completed by Ernst & Young in January, 1990, shows how hospitals must subsidize the expense of Medicare patients. As recently as 1986, Georgia hospitals received a 6 percent cost of services return from Medicare, but in 1990 such payments are 18 percent below cost.

Meanwhile, employers and those who are insured increasingly resist the "cost shifting" required to compensate for the burden of the uninsured. Many already pay for those who can't through local property taxes. Cost shifting, they feel, amounts to no more than a "sick tax" added to the hospital charges of those who are able to pay or who do have insurance. Approximately 34.1 percent of a private pay patient's 1987 bill could be attributed to cost-shifting.[8]

In an effort to control health costs and curb cost-shifting, businesses and their insurers have designed extensive measures for monitoring charges. Such mechanisms include utilization review, precertification, concurrent review, preferred providers organizations, and health maintenance organizations (HMOs). It is the inability to shift costs, however, that is further crippling our hospitals' chances for survival.

Alternative Solutions

Unfortunately, the increasing number of uninsured Georgians is a problem with no clear-cut answers for either the providers caught in the middle or the communities that depend on their services. But one thing is certain. Basic health coverage, or "bare bones" insurance packages, must be made available to those who do not have traditional insurance benefits. These packages must provide coverage for primary care, inpatient hospitalization, ambulance and emergency services, lab services, and limited psychiatric benefits. If structured under the auspices of the state government, they would cost significantly less than private insurance alternatives and could be offered on a much broader basis.

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State-sponsored health insurance is gaining support across the country. It can be made affordable through subsidized premiums, provider discounts, efficient claims processing, and limits on provider liability.

The state of Washington currently is conducting a pilot project in five communities. The program, called Basic Health Plan (BHP), targets people under age 65 who do not qualify for Medicaid and whose income is below 200 percent of the federal poverty level. BHP offers coverage for physician services, hospital inpatient care, prenatal and maternity care, lab and X-ray services, emergency services, vision and hearing care, and preventive care.

Participants are required to make co-payments on some services. In addition, they must enroll in managed care plans contracted by the state with hospitals and physicians that are willing to offer discounts for their services or to provide them at cost. There also is a one-year exclusion for treatment of pre-existing conditions, except for pregnancy.[9]

It is possible for us to initiate a similar program here in Georgia. The major decision to be made is how the premium subsidies can be financed and how extensive they should be. The Washington prototype uses state appropriations to subsidize premiums. However, it may be difficult to find the funding necessary for such a program in our state budget.

Georgia should explore a variety of other options for funding a sliding scale premium that would make insurance available to low-income citizens. While states like Washington view the uninsured problem as yet another societal burden and rely strictly on general purpose revenues for their programs, several have turned to alternative funding sources. Ohio, for instance, is considering a payroll tax on employers who do not offer health insurance. Some states have raised needed funds through so-called "sin taxes" on alcohol and cigarettes, since there is a common belief that people who use these products are major contributors to health care costs and should pay more to subsidize the health care of others.

Whether or not a state-subsidized health insurance program would be effective in Georgia depends to a large extent on the source of financing and the cooperation of providers, insurers, and businesses. Georgia's hospitals are willing to address all viable alternatives, including discounted reimbursement, in order to make such a plan work.

It has become painfully evident over the past few years that action must be taken to address the growing number of uninsured Georgians. The longer we wait for the federal government to act, the more desperate the situation will become. The Georgia Hospital Association does not believe that a state insurance program is the answer to every problem for every hospital. But our member hospitals do realize that increased availability and affordability of primary health insurance coverage means that extreme emergency care can be avoided in many instances.

Hospitals view the problem as one that affects the overall quality of the health care delivery system. The development of a Georgia program for the uninsured will put our values in the forefront of a national solution — a solution that must be found soon. The health of our citizens and the future of our hospitals hang in the balance.

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Health Care Reform: Cultivating a National Consensus

Louis W. Sullivan, M.D.

Introduction

THERE ARE MANY serious health issues which challenge our nation. Certainly, one of the most pressing is the high cost of health care. In this article I will mention the immense dimensions of that problem and discuss some potential solutions. Then I would like to discuss the contributions of our biomedical research efforts, which are rapidly changing the medical landscape. The Department of Health and Human Services has made biomedical research a top priority, and I will discuss our work to stimulate and enhance that research. Finally I would like to talk about our need to foster a culture of character. Health promotion and disease prevention must become a personal and national priority, with an increased emphasis on personal awareness and practice of healthy, responsible behavior.

The High Cost of Health Care

The high cost of health care now threatens to overwhelm and engulf us. In the United States, health care cost the American people more than $530 billion — 11 percent of our Gross National Product in calendar year 1988. Some estimates are that these costs will be over $600 billion in 1989.

We must take the time to develop and cultivate a national consensus — which means generating debate, increasing awareness, presenting a full range of options, and forging agreement on the actions we must take.

The costs are likely to keep on rising. My department estimates that, unless changes are forthcoming, health care costs will reach $1.5 trillion by the year 2000. What makes this doubly frustrating is that there is some evidence that perhaps as much as 25 percent of what we spend for health care does not buy needed care or provide an increased measure of quality. But all of us — patients, physicians, health care providers, and policy-makers — are agreed that any reduction in the high cost of care must not compromise quality. That must be the premise of any discussion.

Of course, hospitals and physicians have been encouraged to find more efficient ways to deliver health care, and the Prospective Payment System adopted in 1983 helped reduce the growth rate in hospital health care costs dramatically. I am certain that the recent physician payment reform package enacted by the Congress and signed by the President will help reduce the substantial increase in physician reimbursement costs, which have been rising at a compounded rate of over 12 percent yearly.

But we must do more, and the President asked me in his State of the Union Address to examine this issue, especially as it relates to the 31 million Americans who do not have adequate health care insurance.

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The Pepper Commission has already weighed in with its findings. I am in the process of examining that report very carefully. The members of the Commission made a sincere and commendable effort to address tough, divisive issues. The many differences of opinion reflected in the report indicate the wide range of views concerning health care financing.

Their disagreement underlines a very important consideration — we must build a strong national consensus on health care. As we learned over the last 2 years, the Administration and Congress can invest considerable time and resources in drafting and passing legislation, only to have that effort backfire — catastrophically.

The many differences of opinion reflected in the report of the Pepper Commission indicate the wide range of views concerning health care financing.

Of course, something must be done to reform health care. But the specific actions contemplated cover the whole political and economic spectrum. Unless we take the time to develop and cultivate a national consensus — which means generating debate, increasing awareness, presenting a full range of options, and forging agreement on the actions we must take — then we run the risk that history will tragically repeat itself, by promising *hope* without giving the American public *solutions* that they can live with.

Also, it is important to give the other groups time to finish their work in the coming months, such as the Advisory Committee on Social Security, chaired by Deborah Steelman. I have also asked a White House Domestic Policy Council Working Group, chaired by Constance Horner, HHS Undersecretary, to report to me on health care financing options.

Yet, simply throwing money at our health care problems, by itself, is no solution. I am concerned about inefficiencies in the system, and I am haunted by a fact I mentioned earlier — as much as 25 percent of our resources are being wasted. I noted with some interest the following comment by the London *Economist* about the Pepper Commission report: "The care of America's needy requires not more money, but a determined quest for a more efficient system." There is a great deal of truth in that assessment.

Finally, the cost of the proposals mentioned in the Pepper Commission report — $66 billion — perhaps as much as $100 billion — is astronomical. And even if we could find this money, through whatever means, unless further efficiencies are created in the system, we could be literally throwing valuable resources down the drain with little improvement in health care delivery or coverage.

All in all, the search for solutions will be long, demanding, and painful. It will require us to examine our values, our resources, and our commitment to health care. It will demand the careful judgment of each of us, balancing a wide variety of concerns. It will undoubtedly require compromise. It will require statesmanship and vision. We need the Administration, the Congress, the health care community, and the American citizens to all contribute in the formulation of sound, workable proposals.

Health Care and Technologic Advancements

Now I would like to turn from our discussion of health care economics to a consideration of our biomedical research efforts.

Biomedical research is the cutting edge of tomorrow. It will revolutionize the delivery of health care. For example, we are on the verge of developing a blood substitute that could be used in transfusions. A substitute for "the real thing" would be of inestimable value because it would be free from contaminants like hepatitis or the AIDS virus, not to mention its value in providing a steady supply. Scientists are also rapidly closing in on treatments for diseases that turn the body's immune system against the body's own tissues. Treatments are already available for arthritis, diabetes, and multiple sclerosis, but biomedical technology carries the hope of a cure for these and other equally devastating diseases.

Cognizant of the need for biomedical research, I have made strengthening our biomedical research enterprise a top priority at my department. We have already developed a Biomedical Research Initiative in the Public Health Service. We will:

- Strengthen the basic research foundation in the biomedical and behavioral sciences;
- Assure the scientific integrity of our research;
- Educate the public about the importance of animal research and assure animal welfare;
- Promote scientific literacy and improve biomedical science education; and
- Improve the intramural research programs of our Public Health Service.

This initiative will help us channel new resources and personnel to strengthen our capabilities in the biomedical, behavioral, and epidemiologic sciences.

On another front, one project that interests me personally is our effort to map the human genome — literally to understand the information encoded on a human chromosome.

Certainly, such an effort will be very beneficial to all mankind. But charting the map will be no small task: the completed map will contain 50,000 to 100,000 genes, and will describe the genetic linkages and physical locations of the chromosomes and determine the nucleotide sequences of all the base pairs of DNA. If and when such information is available, it could lead to wholly new strategies for the prevention and treatment of more than 3,500 diseases of known genetic origin and to a much better understanding of other diseases that have genetic components, such as cancer, depression, and hypertension.

Mapping the human genome will have a momentous impact on medical science. It will change the very practice of medicine.

This research will have a momentous impact on medical science. It will change the very practice of medicine. Scientists may soon be able to correct genetic defects, prevent illness, and provide better treatment for disease. That is why Nobel laureate Walter Gilbert has labeled the human genome project the "Holy Grail" of genetics. But perhaps Norton Zinder of the Rockefeller University was closer when he called it medicine's "Rosetta Stone."

A Character of Culture

So far I have outlined our efforts to stem the cost of care and the substantial contributions of biomedical research. But in the formulation of a sound national health care strategy, we must also reform attitudes and change behaviors that contribute to preventable disease. Prevention must be our first line of defense. It is less expensive and more humane to prevent disease than to treat it at a later date.

As Secretary, I have tried to make health promotion and disease prevention a national crusade. Prevention of illness is a responsibility we have to each other. It not only allows for more freedom and happiness, but prevention practices can free up more resources for those who become ill.

In my public speeches and other presentations, I have asked each American to accept personal responsibility for better health behavior and practices. That includes the adoption of better dietary behavior; proper vaccination; the moderate use of alcohol or the absence of alcohol; the elimination of illegal drug use and smoking; use of seat belts; and other prevention practices.

Statistics show that prevention is the most important factor in providing better health care today. Early detection and intervention, immunization, and behavior change could significantly reduce many of the leading causes of death and disability. It has been estimated that we could eliminate 45 percent of deaths from cardiovascular disease, 23 percent of deaths from cancer, and more than 50 percent of the disabling complications of diabetes.

Better control of fewer than 10 risk factors — such as poor diet, infrequent exercise, the use of tobacco, alcohol and drug abuse, and use of seat belts — could prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability.

We have a long way to go in the United States before most Americans understand the importance of healthier behavior. But it is an essential part of any strategy to make our citizens healthier and also to lower some of the costs of health care. We must be cognizant of our interdependence, expressed in a wonderful statement by my mentor at Morehouse College, Dr. Benjamin Elijah Mays: "The destiny of each individual, wherever he resides on earth, is tied up with the destiny of all men who inhabit the globe."

In the formulation of a sound national health care strategy, we must also reform attitudes and change behaviors that contribute to preventable disease.

Conclusion

We must contain the high cost of care. We must continue the progress of biomedicine. And we must work to create a culture of character. These are big challenges that require a vision, dedication, and commitment. They require all of us to work together.

We must remain determined, regardless of the problems we encounter. The spiralling cost of health care will not be reduced overnight. There are no magic wand solutions. Progress in biomedicine is a slow, painstaking task. And changing personal behavior in our effort to create a healthier society will take a number of years.

But as physicians, educators, researchers and scientists, we understand, perhaps as well as anyone, that we can achieve a great deal if we simply keep on working to achieve these goals. That is our challenge; it must continue to be our commitment. ■

What Physicians Owe Hospitals: An Overview

Merlin K. DuVal, M.D.

When Alex McMahon first asked me to discuss his plans for the forum this year, he asked me to talk about "what physicians owe hospitals." He'll tell you that I expressed great discomfort with the assignment and that I asked him if I could speak on the other topic, "what hospitals owe physicians." He assured me that he wanted me to take the topic he gave me precisely because I was uncomfortable with it.

Well, my initial instincts were sound. I have suffered ever since, and for one good reason: the answer to the question of what physicians owe hospitals clearly depends on whom one asks. For example, I recently talked to a number of colleagues who represent the viewpoints of hospital administration and, frankly, their list of things they think the physician owes the hospital is pretty long. But I have also asked the same question of a relatively large sample from a medical staff whose size approaches 3,000 and, to my surprise, got a remarkably consistent answer, namely, "Nothing." In fact, most physicians seemed surprised with the question, as if it were inappropriate.

It seems to me that there is real utility in recognizing that views as disparate as those between physicians and hospital administrators can find a justification in contemporary history.

It seems to me that there is real utility in recognizing that views as disparate as those between physicians and hospital administrators can find a justification in contemporary history. In other words, the perceptions held by members of a hospital medical staff and those held by members of the hospital's governing body and the administration have been genuinely different for very good reasons. Members of a hospital medical staff genuinely believe that the hospital exists primarily to meet their needs and the needs of their patients, that it constitutes a resource center that offers an intensity of care and technology as an extension of their own offices for the care of their own patients. In other words, the hospital is there for their convenience. (This viewpoint was well described about two years ago by Regina Hertslinger in

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the *Harvard Business Review.*) Hospital trustees and administration, on the other hand, see the hospital as a corporate entity that is created within and for and is accountable to the community, as a place to which all patients within that community can go for care.

Inasmuch as both the hospital and the medical staff clearly need each other, this situation resembles a marriage that has been made in hell but from which divorce is not permitted. Within that context, and without defending the viewpoint of the hospital administrator and his list of things the physician owes the hospital, and without defending the viewpoint of the physician who believes he owes the hospital nothing, I have chosen to describe not only what I believe the physician ought to owe the hospital, but why — even while acknowledging that things may not be this way in the real world.

My admonitions will generally avoid particular reference to physicians as independent contractors, but rather will be oriented toward physicians as members of a medical staff, an entity which serves as a creature of the hospital and has neither existence nor standing outside of its walls. Similarly, these views will be much more relevant to members of an open staff than to members of a closed staff, because the open staff is the typical mode of practice arrangement in the United States, and because closed staff covenants frequently encompass many of the physician obligations that I plan to address anyway.

I believe that there are nine things that physicians owe hospitals. And for the purpose of this presentation, I will categorize them under three headings — loyalty, cooperation, and participation.

As for loyalty, today more than ever before, when the physician has the discretion to choose the institution to which he will admit his patients, he should generally admit them to one hospital. As managed care contracting and selective purchasing by large employers increase in intensity, it seems inevitable that the physician will lose some of that discretion. Nonetheless, splitting admissions between competing hospitals for reasons other than meeting payer requirements is, in a competitive environment, not a good practice and should be avoided, for the same reason that good computer engineers who work for IBM are not shared with Apple.

Splitting admissions between competing hospitals for reasons other than meeting payer requirements is, in a competitive environment, not a good practice and should be avoided. . . .

Second, medical staff members should avoid the overt conflicts of interest that may arise from serving more than one hospital in administrative or management positions — for instance, committee chairmanships. This is especially true of policy-level responsibilities. In a highly competitive marketplace, physicians who can exploit proprietary information do not complement themselves or their colleagues, and may actually damage hospitals that they genuinely care about.

Third, physicians should attempt to avoid direct economic competition with their primary hospital. In most instances, such action leads to a breaching of the commons, in which a relatively small personal gain by such physicians fails to offset the bleeding away of hospital revenues, to the detriment of the institution as well as to other physicians in the community.

With respect to cooperation, physicians owe their hospital prompt completion of records and attestations. It is the hospital's cash flow that is compromised when physicians fail to pay attention to such duties. If there are a hundred charts incomplete at any given moment as a result of inaction by the medical staff, that is equivalent to expecting the hospital to go to the bank and borrow a million dollars against its outstanding accounts because the incomplete charts preclude billing.

Fifth, physicians also owe the hospital the appropriate use, or at least the avoidance of abuse, of such functional entities as 24-hour observation wards and emergency rooms. After all, these are not entities that are set up to serve as substitutes for their office practices.

Sixth, physicians should realize that they have a stake in actively cooperating with hospital risk management programs, in view of the fact that, with virtually no exceptions, the hospital is both accountable to the public and responsible to the plaintiff for the behavior of its medical staff members. (More on this below.)

Regarding participation, physicians must be actively involved in the selection and application of that science and of those technologies that are appropriate to their hospital and to their communities. When asked, they should definitely participate in governance and, where appropriate, in the management of their hospitals. Finally, physicians must actively participate in the preparation and implementation of quality of patient care standards and quality assurance activities, including, but not limited to, evaluating and reevaluating candidates for medical staff appointments and taking action against those of their colleagues on the medical staff who are either impaired or incompetent.

If some of you believe this list is a little bit overdrawn, I would like to suggest that there are at least three circumstances that give legitimacy to this list of physician obligations.

First, it is very clear that society continues to grant physicians very special status and privilege. For example, we know that among any 100 patients with an illness that requires medical care, about 90 can be taken care of on an ambulatory basis in the physician's office. Ten will require hospitalization, one of which will probably require the resources of a tertiary care institution.

Within the context of that scenario, in most industrialized nations there would be a discontinuity of care for those ten patients who require hospitalization. While the patient might be seen first in the physician's office, if hospitalization is necessary, responsibility for his care then would be transferred to a different, hospital-based physician. In the United States, however, society permits all of its licensed physicians to seek hospital admitting privileges for themselves. And although dermatologists and allergists may find this of less importance, most other practitioners find it very important, because it not only permits them to render continuous professional care to their patients but permits them, rather than someone else, to capture the fee income that is generated while the patient is hospitalized.

This same society also welcomes all community physicians into hospital staff membership, provided only that they meet certain predetermined and relatively minimal criteria. Thereafter, once such a physician is credentialed, he can care for his patient as if he were an independent practitioner, even while simultaneously joining his colleagues as a member of an organized medical staff with status essentially equal to that of the hospital board of trustees. Not only is this medical staff then permitted to choose the criteria by which those who follow are to be credentialed, but the physician member may be invited to participate in the governance of the institution or otherwise be encouraged to participate as a committee or department chairman — in other words, to engage in management. It is through these structures and this practice that standards for the hospital, and indeed for the entire community, are set and that the profile of services to be offered to the community is determined.

It is probably even more important now than ever before for both parties to recognize that the demands being placed on them by payers should result in forging a partnership rather than in fostering tension.

Since the hospital is created as a site for quality care of those in its community, and since members of the hospital board are essentially free to choose the means by which they fulfill this obligation, it also follows that many nonphysician health care practitioners may also seek hospital privileges. In such instances, the board of trustees generally delegates to its physician medical staff members the right to determine who among such practitioners or petitioners shall have privileges in the hospital, as well as the responsibility for supervising their performance, be they podiatrists, psychologists, or dentists. Thus, while some might feel that the physician is a guest in the house of the hospital, it seems to me that he is somewhat more nearly the house master. Surely, in exchange for receiving such broad authority from the board, this physician owes the hospital something.

In 1965, the *Darling* case had the effect of assigning responsibility for what takes place in the hospital to its board of trustees. Ever since, and with almost no exception, it has been the board that has been held accountable for the quality of practice of each of its physicians, for the physician's reputation, and now for his behavior. The degree to which the board can be held accountable for the behavior of members of its medical staff is joltingly illustrated by the recent judgment of the Supreme Court of Massachusetts in *Copithorne v. Framingham Union Hospital.* In this case, a medical technologist at the Framingham Union Hospital injured her back during her employment. For treatment, she turned to a neurosurgeon who practiced within the hospital and who enjoyed an unusually fine reputation. In the course of his treatment, the physician made a house call to this young woman's apartment, where he allegedly drugged and raped her.

When this case first came to trial, the court held that it was not the hospital's duty to protect the employee. However, the Supreme Court of Massachusetts reversed on the grounds that the hospital did indeed owe a duty of care to its employee because she chose for her treatment a physician the hospital itself had found acceptable for credentialing. And although there are other circumstances that attach to this case, they do not change the basic premise that since hospital trustees may now be responsible for the acts and actions, professional and otherwise, of the medical staff, delegating to that same medical staff the responsibility for determining who shall be its colleagues constitutes an incredible quid for which I think they have a right to expect a quo.

By the early 1980s, it was clear that all efforts to control costs through regulation and through the "voluntary effort" had failed. Consequently, our country moved to adopt new payment schemes for health care services that involved either prospective pricing by the federal government for its Medicare beneficiaries or, alternatively, managed care contracts and selective purchasing by American businesses. Both the federal government and private employers were looking for the best price they could get when they purchased health care services for their beneficiaries or employees. These financing schemes had the effect of reversing all customary incentives. Whereas in the past, the more one did, the more one was rewarded, under prospective pricing, the more one does, the less he might take home. Clearly, undertreatment becomes a threat. Furthermore, concerns about the erosion of quality as well as of professional ethics have gained currency in the context of these reversed incentives.

Such circumstances should have resulted in closer alliances between medical staffs and their hospitals because now they have a common enemy, the payer. Unfortunately, the result was often the opposite. Indeed, tensions between medical staffs and hospitals increased, principally because of the manner in which these new payment schemes were implemented. Under these current financing schemes, the hospital is held hostage for the decisions that are made by its physicians.

Let me illustrate. When a patient is admitted to the hospital with a diagnosis of peripheral vascular disorder with a complicating condition, the diagnosis is assigned DRG number 130 and a relative weight of 0.8776. This determines the amount of money the hospital is going to receive for that admission. It is just as if that amount of money were deposited in a bank, after which the admitting physician was given a credit card that could be used against that bank deposit. However, the physician does not usually get to see the bank statement that attaches to that account. Therefore, he may continue to spend against it for laboratory or other ancillary services, without regard to its balance.

There are other reasons that physician/hospital tensions are increasing, an appreciation of which will escape hospital administrators until they become more sensitive to what has been happening to physicians.

Hospitals, already saddled with shrinking margins as a consequence of prospective pricing and discounted contracts, have become increasingly anxious over the behavior of their physicians and have responded by asking them to participate in utilization review. The typical attitude of the physician in the field is that he will do so, but only if he is paid to do so. After all, it is hospital resources that are at risk, not his own. However, for the privilege of spending the hospital's money for the care of his patients, he surely ought to owe the hospital something.

It does not end there. All hospitals that choose to participate in Medicare, for instance, must comply with federal "conditions of participation." These encompass patient safety, qualifications of physicians, medical staff standards, and so forth. Failure to meet the conditions of participation result in sanctions, up to and including disbarment from the Medicare program, all against hospitals, none against individual physicians, and none against the medical staff.

Similarly, under the Consolidated Omnibus Budget Reconciliation Act (COBRA), hospitals with emergency departments are mandated to provide emergency care. No corresponding duty is imposed on the medical staff. If a physician should refuse to participate in covering the emergency room, it is the hospital that is in violation, not the physician.

If hospital medical staff standards are not met, hospitals can lose their accreditation from the JCAHO, but no penalty is visited on the physicians, who, you might recall, requested and were given the responsibility for determining and acting on those same standards.

There are other reasons that physician/hospital tensions are increasing, an appreciation of which will escape hospital administrators until they become more sensitive to what has been happening to physicians. As payers and regulators increased both their involvement in and intrusion on the practice of medicine, physicians necessarily became increasingly frustrated. This began when physicians were stiff-armed by unfair competition from federally funded HMOs. Shortly thereafter, they were invited either to join HMOs or IPAs and go at risk financially, or not join and lose patients to their competitors. Next came the extraordinary growth of managed care and prospective pricing, discounted fee-for-service programs which brought quality assurance to the fore with its record reviews, its citation of adverse patient occurrences, trending, and so forth. This was followed by threats to their loss of certification as medical staff members, by the intrusion of utilization and peer review from

PROs looking at medical necessity and appropriateness, by the sanctions of the Health Care Quality Improvement Act, and now by denial of payment for care that someone somewhere else has decided is unnecessary or inappropriate.

Even the value of what physicians do is under attack by those who propose payment based on relative value scales or caps on physicians' reimbursement. If any of our physicians react to this kind of heavy-handed intrusion into their professional practices with either resentment or anger, it will unquestionably mar their relationships with their hospitals. And when the hospital attempts to change physician behavior because it is being held hostage for the decisions made by the physician, this makes the situation worse. Instead, it calls for a high level of understanding, and even compassion.

What I think this points up is that stress in this uncomfortable marriage involves both parties and involves bilateral concessions. Consequently, it does not seem unfair to me to ask physicians to be loyal, to cooperate, and to participate as a quo for the very considerable quid they ask for and receive from their hospitals. It is probably even more important now than ever before for both parties to recognize that the demands being placed on them by payers should result in forging a partnership rather than in fostering tension. If this conference can get us to recognize that, rather than focusing only on what each of us owes the other, the entire experience will have been worthwhile. ■

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AIR FORCE

What Physicians Owe Hospitals: An Administrator's View

W. Daniel Barker

I THINK one of key things that physicians owe hospitals is a keen awareness and understanding of the environment in which we live and work and provide our services. We have 177 million people in America whose insurance coverage, or at least a majority of their premium, is picked up by their employers. Granted, we have 37 million people who may be uninsured, of which 21 or 22 million of those people may be working, but the majority of our patients have their insurance paid for by their employer.

It has been said many times that business is concerned about the high cost of health care. They are getting tired of dealing with 6,000 different hospitals and 500,000 different physicians. They want one global fee that covers everything and they want to be able to deal on a case-by-case, disease-by-disease basis and they want to do it in a cost-effective way. Putting those things together, will the hospital determine what the physician's fee will be, or will the physician determine how much is left over for the hospital to keep?

The efficient use of our services and the effectiveness of our organization can best be amplified through an individual physician who understands what it is all about.

Understanding this environment is fundamental if we are to have the type of working relationship that we need, and I think physicians owe hospitals that understanding. There is a flip side to this as well. Hospitals also have a responsibility to make sure that physicians understand the hospital's perspective of that environment.

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In this day in which a lot of hospitals are advertising in order to have a more competitive position, we are finding more and more that hospitals are attracting patients rather than patients being referred to hospitals by physicians. At the same time, we are seeing a new national rating system being developed, and physicians need to understand what is happening as far as that is concerned. The mortality statistics that are issued by HCFA regarding Medicare patients try to rank the quality aspect of our services. If we look at the ranking system that is being developed by third-party payers for their HMOs and PPOs or, in some instances, by large employers when they pick certain hospitals because of their "quality and cost effectiveness," what type of working environment does this create for our hospitals and our medical staffs?

These are tensions that are growing day by day. It might seem peaceful here in Durham, North Carolina, today; but the world is not as utopian as it may seem. These are factors with which we must

reckon. There are concerns that affect us all, and I think physicians owe us an understanding of this environment just as we owe them a presentation from our standpoint of that environment.

If we are going to avoid an adversarial relationship, it is important that we have a partnership, and that involves bringing our medical staff and our individual practitioners into our internal organization.

I think physicians have an obligation to provide quality care, and that includes the efficient use of our resources. Patients who stay in hospitals unnecessarily long or who are subject to tests that are not really warranted do not benefit either party. The efficient use of our services and the effectiveness of our organization can best be amplified through an individual physician who understands what it is all about. These are important factors. Often HMOs or PPOs or other organizations choose only certain members of our medical staff to be involved in providing care to their subscribers or employees. We are still obligated to continue the medical staff relationships with physicians who were not picked.

The organized medical staff and the cooperation of individual practitioners are important parts of the quid pro quo between hospitals and doctors. We have to find a better way of providing health care. It is getting too expensive. We are almost to the point at which we are spending $2 billion a day on health care. In many instances, it is compromising the employer's ability to price his product competitively in the global market. Not too long ago, the vice president of human resources at B. F. Goodrich Company addressed this issue. He said:

As business managers, we've seen firsthand these dramatic increases in health-care costs. We've spent considerable time and energy evaluating our benefits packages, and in many cases, redesigning programs. We've wrestled with the difficult decisions involved in providing our employees and retirees with quality health care — while battling increasing costs. But do we really understand what the continuing health-care cost spiral means to our profitability and to our ability to compete in what is a global arena?

Do we really understand the threat that these costs represent to the future of our organizations — and the fact that those companies that gain control of this issue will also gain a real competitive advantage?

Do we really understand that health care is an issue that demands a long-term management viewpoint and strategy — a ten-year view that encompasses where we are and where we must get to?

Do we really understand that this isn't solely a management issue and that we have to extend our thinking to work in partnership with many differing groups — particularly employees, retirees, health-care providers, public officials, and organized labor?

Do we really understand the dynamics of this issue from the standpoint of the changes that are taking place in our society — and in our own work environments?

I believe the answer to these questions is no.[1]

I do not think we are ever going to have a national health policy like some other countries because our health care activities have been from the community level up, not from the national level down.

The figures that we have just received from the American Hospital Association for 1988 show that the average hospital in this country had an operating margin from patient revenue of zero percent.[2] That is the average. That does not give us much flexibility. No one can stay in business with a zero bottom line unless philanthropy increases and somehow or other the goodness of the nonprofit enterprise recaptures the spirt of giving in the American public. In order for that to happen, we — hospitals and physicians alike — have to present a better picture as far as the press is concerned, as far as the government is concerned, as far as the man in the street is concerned, and most importantly, as far as our patients are concerned.

It has not been too long since patients said, "Not only will I do whatever my doctors tell me to do, I'll go to whatever hospital he asks me to go." That is somewhat different today. Many patients say, "I'll only go where my insurance company will pay the majority of the bill, or I want to go to Hospital X, Y, or Z because, from what I read about Medicare quality from mortality statistics, it has the best quality." Things are drastically changing and in order for us to keep on top of the situation, it is important that our medical staff (and particularly the individual physicians) understand this.

In the March, 1989, issue of *Trustee,* Richard Umbdenstock looked at the old concept of the three-legged stool — the governing body, the physicians, and hospital management — and said maybe it was time to change that concept to something similar to a tripod.[3] You still have three legs, but they are flexible. One of the three legs might be a little longer or stronger or shorter than the other two, but it is necessary to have that type of flexibility because the terrain in which we are now working has changed. We no longer have a level terrain, and I think physicians owe the hospital an understanding of the responsibilities that are ours and the need for flexibility.

As we look at what is happening with managed care, we should take note of what is happening in California, where up to 85 percent of all patients treated in that state are covered under some type of HMO or PPO. What happens in California often spreads eastward over time. Although that phenomenon has not penetrated this area yet, I think that global fee concept is about to hit us and we must be certain that our medical staff understands the pressures that are facing us.

The comments that have been said today were well summarized by the seven points Mrs. Herbert Holmes listed in her expectations of the medical staff. I mention them again:

1. Quality patient care
2. Institutional loyalty
3. Financial support
4. Honest and open communications
5. Being a team player
6. Respect for coworkers
7. Ethics

I think it was Yogi Berra who once said, "If you don't know where you want to go, you are liable to end up somewhere else." We need cooperative, participating, and loyal physicians as members of our medical staffs, and they deserve the same from hospitals. If we are going to avoid an adversarial relationship, it is important that we have a partnership, and that involves bringing our medical staff and our individual practitioners into our internal organization. They need to be a part of management, they need to be apart of governance, and when they are given these opportunities, they should take full advantage of them.

Much progress has been made in medicine in our country. Life expectancy was a little over 40 years at the turn of the century, and now it is over 70. For every week that has gone by, two days of extra life have been given to the average person living today. That is a tremendous benefit. That is a better dividend than any monetary investment that I can imagine.

Although I am very concerned about the environment in which we are operating today, I am still confident about the future. Granted, we have a few rough spots ahead of us. We do not know what will happen if the Stark amendment passes, and we do not know whether joint ventures that help us bond our medical staff together will be permitted. One of the problems that we face is that we do not know where the "safe harbors" from federal regulations are, while the waves keep getting higher and higher.

Maybe the time has come to refocus our thoughts. The reason we have 6,000 hospitals in our country today is not because we had a national health policy that said that we would have this many hospitals. The reason we have this many hospitals today, as we all know, is because they were created to meet a local need, whether they were initially established by physicians or by community support or because of other reasons. They were organized to meet specific community health care needs and that motivation, that desire, is still there today. I do not think we are ever going to have a national health policy like some other countries because our health care activities have been from the community level up, not from the national level down. Granted, we have problems with a deficit budget as far as the federal government is concerned, and we have real concerns from the standpoint of business about how they are going to pay their health care costs and still be able to produce a competitive product in the world market. But I still think that there is enough common interest and enough pride in our service to the sick that we will be able, through partnership arrangements, to continue to meet the health care needs of the communities we serve. And we will do it by realizing that there is a quid pro quo, that there are responsibilities on the hospital side to the physician and, likewise, there are responsibilities on the physician side to the hospital.

Although the phenomenon has not penetrated this area yet, I think that global fee concept is about to hit us and we must be certain that our medical staff understands the pressures that are facing us.

Although there are a few isolated instances in which things are not going the way they should go, I think all of us are interested in the same thing. I do not think it is always fair to tell the physician who is a member of our staff that the economic interest of our hospital must always come first. Nor do I think it is fair for the physician, because he has

to wear many different hats, never to put on his institutional hat. I do not think that is the type of day-to-day environment we have. I do think there are those who try to publicize a few instances where that might occur to the disadvantage of us all. We are all in this together — what hurts physicians also harms hospitals, and the converse is equally true.

What physicians owe hospitals is a debt that basically is paid day in and day out by the way they assume their responsibilities, by covering call in the emergency room for which no pay is received, by the way they give of their time for quality assurance activities in our organization, by all the many things that they do day in and day out to make sure that our unique major mission — treating patients and helping them retain their good health whenever possible — is always at the forefront of our activities.

We are almost to the point at which we are spending $2 billion a day on health care. In many instances, it is compromising the employer's ability to price his product competitively in the global market.

When we talk about responsibilities, I for one am pleased that from the standpoint of the physician, as well as from the standpoint of the hospital, that these obligations are recognized and that they are being met. Granted, there are some environmental factors that we must face, but I am proud that I am in the health care field. I am proud of what we are doing and I think the results, particularly for this century, certainly say that we have done a good job. There have been some inefficiencies, but we are trying to address those. The challenge that we must face now is how we can all work together in a partnership relationship rather than an adversarial one. Once physicians and hospitals get their acts together, we can go to the communities, we can go to business, and hopefully we can go to government, and then we can put in place the type of environment that all of us long to have.

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What Hospitals Owe Physicians: A CEO's View

Jack A. Skarupa

FIRST OF ALL, we must define our own personal view of the physician and the organized medical staff. The physician has been called a customer of the hospital. But if he is a customer, he is a unique customer. Normally, he is limited to shopping in one place. He orders but does not consume his products. His livelihood depends on how well his institution performs. These characteristics make him different.

With this in mind, there are several things that we owe physicians. First, we owe physicians the opportunity to succeed. By this I mean that I want them to be clinically successful; I am not concerned about their finances. But if physicians are going to be successful, then we have to create an environment in our institutions in which that success can come about. If physicians succeed in caring for their patients well, then we succeed. If they do not, then we fail.

Another thing that physicians need is an environment in which we allow them to participate in the business of the institution, both formally and informally. I think one of the most difficult things to do in a hospital is to blend management with the organized medical staff.

If we are to generate interest among physicians for the economic well-being of the hospital, I do not see how there cannot be that same interest on the part of the hospital for the physician.

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I want to be responsive to the concerns and problems physicians have. If I do not hear what is being said, I cannot do anything about it. So another thing we owe physicians is a structure that relates well to their medical staff structure. We need to be at every section meeting, at every department meeting, at every medical staff meeting, and at every executive committee meeting to hear their comments and concerns, and then do something about them.

We owe it to physicians to be responsive to their needs. And we owe them the opportunity to participate appropriately in the affairs of the institution. I would be terribly frustrated if my livelihood depended on your organization and I had no input into it. If there is going to be the opportunity for physician participation, then it needs to be structured. And it needs to be structured right at the very top, with their leadership, management, and governance. You can start with just the basic mission of the institution. Or you can start with the goals of the institution, the philosophy of the institution, and the direction in which it is headed. Physicians need

to be given the opportunity to participate in setting goals on a macro level as well as on a departmental, clinical level. If that opportunity does not exist, then you are going to have considerable frustration.

Hospitals also owe physicians the opportunity to practice at their optimum skill level. To me, that means having appropriate programs, services, equipment, systems, and people. Without these, they are extremely limited in what they can do.

We also owe physicians a high-quality institution. We owe them the opportunity to participate in quality assurance and quality assessment programs, to assist them in the conduct of medical staff affairs. There are people and resources that we owe them if they are to carry out what their medical staff bylaws say that they have to do.

We owe them the opportunity for continued educational and professional growth. In the hospital setting, we owe them the opportunity to participate in continuing education and, in many instances, to participate in research and other special professional programs.

In many instances, these obligations are carried out quite well. But we also owe physicians other things, such as the opportunity to participate with us in addressing the external problems that are facing our institutions. This is an area in which we have performed poorly, at least in my institution.

The medical staff is naturally concerned with what happens inside the walls of the hospital. It probably starts with credentialing, with who can do what inside the institution. It extends to reviewing quality of care within the institution. But everything is organized internally. I have no committee that deals with external problems related to the medical staff, and yet it is these external pressures that are exerting changes on our institutions to which we must respond.

Hospitals . . . owe physicians the opportunity to practice at their optimum skill level. To me, that means having appropriate programs, services, equipment, systems, and people.

But for the problems that are out there — whether reimbursement, the poor, AIDS, teenage pregnancy, drugs, or the elderly — I do not see us giving the medical staff the appropriate setting and opportunity to get involved in their resolution. I think that we have been too focused inside the institution, and somehow we have to expand our focus outside the institution.

We owe physicians fairness and equity. Is it reasonable to treat physicians equitably when one physician supports the institution 100 percent and does all his medical staff work, and another physician goes around "cherry-picking," so to speak, in several hospitals, and does not do all his medical staff work at your hospital? My answer is yes, because as a customer, as a user of a hotel or something similar, I do not feel a sense of gratitude towards that institution because they have served me well. We have to make our services so good that they want to continue to use them.

As I go about my work, I am looking for that partnership between certain doctors in the organization as opposed to "the medical staff and the organization." I am making a distinction between who is working for the success of the organization and who is only "using" the organization. It seems to me that in this day and age, when most of us are putting survivability at the top of our agenda, we tend to be forced to make those distinctions. Those are the phone calls that get returned first. Those are the programs in medicine that get supported the most. Those are the opinions that are listened to the most carefully.

However, I think the concept of fairness and equity does not mean "sameness." Fairness and equity are a two-way street. There has to be some give and take on both sides. And those who play fair on the other side are the ones you play fair with from the hospital's standpoint.

So far there seems to be a fair amount of agreement that the hospital does not owe a living to the physicians. If we are to generate interest among physicians for the economic well-being of the hospital, I do not see how there cannot be that same interest on the part of the hospital for the physician. I am not sure that is something we owe, but as a pragmatic issue, I do not see how it cannot be present.

My main point is that I want physicians to be in an environment in which they are able to perform clinically as best they can. If they do that, then patient care is going to be superb, and the physician is going to be happy. He is going to feel good about what he does. I want physicians to participate in making our institutions better. I do not want them to be separate. I want to be tied very, very closely to them, because that makes us both better.

Finally, we owe physicians a well-managed institution, a high-quality institution, with people who are committed to quality, in which to practice. ■

What Hospitals Owe Physicians: A Trustee's View

John D. Leech

I CANNOT THINK of a more difficult topic for a trustee to address than "what hospitals owe physicians." I have been in the trustee business for almost 20 years, and frankly, I had great difficulty in thinking of anything that a hospital owes a physician. I thought, "Well, maybe I'm looking at this in a jaundiced way." But I asked my friends and some CEOs, as well as several physicians, what they thought. They scratched their heads and came to the same conclusion. They said, "I don't think hospitals owe physicians a damn thing." But I don't think that response is quite fair.

For those of us who are trustees, it is very difficult when you are dealing — at least as a board chairman — with physicians who are not loyal, who are taking patients elsewhere, who have their own businesses, who are competing with our institution, who constantly want more and more expensive equipment, who cause trouble with the nurses, and who complain about their financial troubles. That is not the way to make me want to discuss what hospitals owe physicians. I think we have it backwards — I think physicians may owe something to the hospital.

With all the difficult decisions that are facing us economically, there is one very simple goal that trustees have for the nonprofit, tax-exempt institution — and that, frankly, is to provide health care to the community, not necessarily at a cost that we can afford, but at a cost that we are willing to pay.

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In all fairness, I thought the term "owe" was a bit inflammatory. So I went back to the *Oxford English Dictionary* to find out what "owe" really means. It says, "To be under obligation to render obedience, honor, allegiance." That was not quite what I had in mind, so I continued. "To have or cherish towards another; a feeling regarded as something to which something should be paid; to bear good will or ill will." Now we are getting somewhere! But how do we get there?" To be indebted, to be beholden to a person or a thing for something." I think that is really what it does mean: a debt.

And how are hospitals beholden or indebted, if at all, to physicians? It is really a contractual relationship. But in order to have a contract, or in order to have a debt, we have to have expectations, and those expectations have to be met in return: "If we provide Y, you'll provide X." Then there will be a debt; something will be owed by one to the other.

If we are going to find out whether we owe physicians anything, we first need to know what our expectations are; second, we need to see if the physicians have met those ex-

I have been in the trustee business for almost 20 years, and frankly, I had great difficulty in thinking of anything that a hospital owes a physician.

pectations; third, if they have met them, we need to decide if we are obligated to give them something in return.

What we really need to decide is what our goals are as trustees of the hospital. With all the difficult decisions that are facing us economically, there is one very simple goal that trustees have for the nonprofit, tax-exempt institution — and that, frankly, is to provide health care to the community, not necessarily at a cost that we can afford, but at a cost that we are willing to pay. There are many ways to provide that care, and the type of care that is provided will determine what the level of physician involvement will be.

I see the hospital today as providing a continuum of care, from the inpatient specialty hospital through the general community hospital to the outpatient treatment centers, rehabilitation, nursing homes, home health, hospice, and even down to providing therapeutic aids, dialysis equipment, and so forth. And in every one of those instances, physician input is required to a greater or lesser degree.

It is elementary, but it is very important to remind ourselves that hospitals can survive only if they have physicians. Similarly, physicians cannot deliver complete health care without hospitals.

I believe that hospitals have six expectations of physicians. I also believe that there are seven expectations physicians should have of hospitals.

First, a hospital needs technical skills. These are very elementary, but I think it is worthwhile to return to them. We need those technical skills to improve.

Second, we must be dedicated to monitoring as well as improving the quality of care. Physicians need to be active in that process. We need to be active in that process collectively.

Third, we need an appreciation of and an ability to work with other professionals. We need physicians to be able to work with nurses, aides, technicians, security people, administrators, board members — everyone with whom the physician comes in contact in the hospital facility.

Fourth, we need physicians to make a genuine effort to work together. Collectively we are delivering health care to our community. It is not the trustees' hospital. Nor does it belong to physicians and other people who represent the institution. We need each other, and we need to make a genuine effort to go forward together to meet the needs of our community.

Fifth, we need a progressive attitude. We need to find new and better ways to achieve our collective goals. To do this we need an openness, an agreement that we will share risks as well as profits, which may come in the form of economic gain, but which also may come in the personal satisfaction that results from delivering better health care.

Finally, and not least, we need loyalty and availability. Physicians should continue to keep the hospital's needs in mind so that we live up to our part of the bargain in return.

There are two things I do not think we owe physicians. First, we do not owe them an income. I do not think that we owe them a standard of living to which they have become accustomed. The physician should make money the old-fashioned way: he should earn it. Second, I do not think we owe physicians patients or the type of practice they desire. Both income and patients will come if we can keep our bargain on an even keel.

We must involve physicians in major decision making and planning activities. Both of us need to be a part of determining where we are going and how we are going to get there.

It is very difficult as a trustee to tell a physician how much he should make. From the institutional standpoint, however, it is exceedingly important that we not pay the pathologist, the radiologist, or the anesthesiologist, who typically are on an ancillary contractual basis, for the privilege of being at our hospital. For our institution, I have taken the position that we will not tolerate that. This obviously indirectly affects the total amount of the income that an individual or group may make.

But we also have to control the fees that are to be charged so that they are competitive in the marketplace. It may drive down physicians' income, but we also have to consider the economic viability of the institution. I would rather set charges from the institutional standpoint than from the standpoint of individual physicians.

So what does the hospital owe physicians? First, we owe them respect — not awe, which I think many of them would much rather

have, but respect for their technical skills, and respect for the fact that they are highly intelligent, dedicated individuals who have a common goal to supply health care.

Second, we need to be fair and equitable in our treatment of physicians, not making arbitrary decisions and not taking isolated actions against certain specialties or certain types of geographically situated physicians, but instead operating with as much equity and justice for all as is possible. This sounds trite, but in fact it gets back to the real essence of what we are trying to do.

Third, we need a forum for discussion. Each individual hospital will find its own way to handle that, whether it be in a committee or in board representation. We need to have a forum so that as difficult decisions are faced, we will have the ability to deal with them openly and collectively.

Fourth, we must involve physicians in major decision making and planning activities. Both of us need to be a part of determining where we are going and how we are going to get there.

Fifth, we need to provide a forum for monitoring and improving quality. We need to collect data which can then be used by physicians and management to monitor and improve the quality of physicians' work. This is the day of the computer, and an institution clearly has the best means for supplying the system.

Sixth, to the extent we possibly can, we need to cut the red tape and permit physicians to do what they do best and what they are trained to do — treat patients.

Finally, we need to provide appropriate equipment and facilities, well-trained personnel, and a progressive attitude. Facilities and equipment are usually given the most attention, but in fact it is the relationship that needs to be dealt with more. If the physician will give us the six items I believe we are entitled to, we will be more than happy to meet them halfway.

What has happened lately is that economic issues have come between us and blurred the very essence of our relationship. This can cause one or the other of us to break the original contractual arrangement. That is, if physicians do not meet our expectations, we can conclude that we will not give anything to them. We have a deeper pocket, so we can cause more grief to the physicians. But in the long run, the grief will come back to us indirectly, because we will not be able to supply the very essence of our existence. As a nonprofit, unpaid trustee, the only reason I am there is to provide health care to our community. ■

What Physicians Owe Hospitals: An Individual Practitioner's View

Donald E. Warren, M.D.

When assigned this topic, I thought it was a bit unusual, but I was attracted to the words "in health affairs." I am from Palm Beach County, and in Palm Beach, we listen when people say "affairs." We like affairs. We talk about them. We write about them. Soon we will even have a television series on one of our most famous affairs.

[Merlin K.] DuVal referred to the hospital/physician relationship as a marriage, but in my understanding, an affair is not quite that formal. And yet when I looked at the topic, "What Physicians Owe Hospitals," I realized that some of the excitement must be gone from the affair, or we would not be speaking about it.

Actually, the title "What Physicians Owe Hospitals" is not bad, but it could have been jazzed up just a little bit. Perhaps we could call it "Has the Excitement Gone out of the Affair? Will They Split? And If They Split, Will One Ask for Palimony?" Or we might title it "Hippocrates, Your Bones Must Be Tired from Turning Over in the Grave So Often."

If the physician pays what he owes, . . . we will see . . . romance . . . back in the affair, the trustees will be more relaxed and have more fun, the administrators will be seen to smile again from time to time, government will have more money, and we will have a kinder, gentler, more ethical America.

Dr. Warren is an internist. This article is reprinted from "The Report of the 1989 National Forum on Hospital and Health Affairs at Duke University."

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I am a pure-blooded practitioner, away from the medical school where large numbers of medical groups and large numbers of hospitals are having great problems. I took medicine as a calling, that God would have me serve my fellow man. I did not think of this as a "career opportunity," as I am afraid many people do today.

I have been practicing 33 years, and for 23 of those, I have been on either the executive committee or the board of trustees. During those 23 years, I have seen every medical applicant to one of two hospitals. I practice in both. I admit equally to them, according to the choice of the patient. (I never fail to ask unless there is a service at one that is not available at the other, which is rarely the case.)

So I have seen these applicants, and I think I have a clear view from the perspective of the physician. The rules have changed. There are more forces. There are more problems and, obviously, tensions between hospitals and physicians—otherwise, we would not be here today. And yet, even though there is less

fun, I must confess that when I get one on one with the patient and away from helping run the hospital staff, I enjoy it as much as I ever did.

When I first went there, the physician was dominated by the hospital. You had your rules, and you abided by them if they gave you privileges. Now it is changing a bit and physicians feel they should help run the hospital, even to the point of extortion and forming an adversarial relationship. And yet, I'm sure the medical staffs like their administration. Recently in my area, a hospital administrator was critically ill. He was going to the operating room on the cart, and just as he started through those ominous doors, he received a wire. The wire read, "The medical staff wishes you a speedy recovery, by a vote of 200 to 199."

The physician owes the hospital the proper selection of patients for admission, the elimination of unnecessary tests, discharge in a timely manner, and the completion of charts on a timely basis so that the hospital's cash flow will not be delayed.

As I collected my thoughts for this paper, I considered the "good old days" and how much simpler my life was then. Yet, in honesty, I had to remember the many things that have happened in those 33 years and how much better medical care now is, how much better the quality of life is, and how much longer the length of life is. I realized then that so many of these advances have added to the problems that we are discussing at this forum. I thought about how the physician has changed and how the hospital has changed and how America has changed. And it seemed to me that there might be some connection between the three. The physician and the hospital should both understand that neither of them is important in itself, because really, only the patient is important. Thus I am really looking at what the two, working together, owe the patient and what the physician can do for the hospital that can help that patient get better care.

The hospital is simply a place to serve the sick. A physician is simply a person to serve the sick when prevention fails, and at times he may well need the help of a hospital. I think the physician owes the hospital the understanding that it is not just a place to earn money, but it is a place to assist him in caring for sick folks or preventing their sickness. This is not new. Almost 2,400 years ago, Plato said in the *Republic,* "No physician, insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient. For the true physician is also a ruler, having the human body as his subject, and is not a mere moneymaker."

If you practice good medicine, money will follow. It almost always does. And that is not bad. I have made much money practicing medicine. I am proud of it; I have earned it. As Gandhi said, "I am not against wealth. I am against wealth that enslaves." I submit that we must remember that wealth or the desire of wealth which alters one's judgment or ethics has enslaved already. The physician owes it to the hospital not to get enslaved.

The physician owes the hospital the provision of quality care to every patient he sees. This is so true that it does not need discussion. But also, the physician who is a little better qualified, a little better trained, or newly trained owes it to the hospital to improve the quality of everyone else. He has new information. He knows about new equipment. He has the obligation to bring the entire medical staff a bit closer to modern medicine.

He should help educate the administration, especially with regard to equipment and other clinical things. He should help educate the nurses, realizing that they are his colleagues on the healing team. They are not hired help; they are coleaders on the healing team. He should also help educate and show respect to the orderlies, the secretaries, and everybody on that team if he wants his patient to get the best care. As he teaches and learns from them, he should encourage, praise, and inspire. Then, suddenly, you have a team working together. I think the physician owes the hospital that type of approach to the people in the hospital, which can help with the retention of personnel, who are so hard to obtain these days, and which is one of the hospital's greatest problems.

I think too many physicians — and I have seen them many times and have had to deal with them — have walked onto the floor as if God had sent them there and immediately taken over and acted as if they were God himself telling others what to do. That is not the role of the physician. It is to be the leader. I am the health advocate for my patient, and I should lead the team to help get him well. Van Dyke said, "It is not a reasonable aim to stand tall in the world, but better to stoop down and lift the whole world higher." That is what the physician should do to help make the care of that team better.

He obviously should also help monitor the quality of care. He owes that to the hospital. He should serve on committees, and I think that all of the committee assignments should be done free of charge. I think that is something that the hospital is owed by the physician once it gives him privileges to use that facility for the care of his patients.

I do sadly lament that many of the physicians coming into practice feel less inclined to pay that particular debt by serving on committees.

I think it is important that the physician protect the hospital legally. Records should be promptly and accurately completed, but in addition, I think the physician needs to admit mistakes early, just as the hospital should record them and remedy them. This is really a solution to malpractice. He must be available or covered. He must respond properly to protect the hospital.

The physician must also treat the poor. I think this is important. Roughly 33 years before Plato wrote that part of the *Republic* I quoted, Hippocrates wrote, "Sometimes give your services for nothing, calling to mind a previous benefaction or present satisfaction. For where there is love of man, there is also love of the art. For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician." I would change that to "the goodness of the healing team." I am convinced that is true. Now, there are limits to poverty. There are limits to what you can do, and I think that sometimes it is all given to one specialty.

The physician should try to understand the hospital's problems. The rules have changed, and this has placed a severe financial strain on many hospitals. Some of the best hospitals are near bankruptcy, while some of those that are not so good are thriving. In this setting, I think the physician owes the hospital the proper selection of patients for admission, the elimination of unnecessary tests, discharge in a timely manner, and the completion of charts on a timely basis so that the hospital's cash flow will not be delayed. I think the physician should be loyal to the hospitals which have been loyal to him, and should not be lured away by promises of greater financial gain.

The physician owes the hospital a high standard of ethics . . . . and to be totally free of conflict of interest.

This brings me to my most important point. The physician owes the hospital a high standard of ethics. Robert Louis Stevenson beautifully said, "There are men and classes of men that stand above the common herd — the solider, the sailor, and the shepherd not infrequently; the artist rarely; rarer still, the clergyman; the physician almost as a rule. He is the flower of our civilization." Yes, the physician owes the hospital, the patient, the community, and himself a high standard of ethics, as medicine is a noble calling, second only to the ministry. The physician must return the flower to full bloom, or else he will be thought of as a labor unionist, a merchant, an entrepreneur, a gouger, or even an extortionist.

Therefore, I think the physician owes it to the hospital to be totally free of conflict of interest. This would include no financial interest in a for-profit hospital; no interest in a for-profit, freestanding surgical or diagnostic unit; and no utilization of these for-profit units, which skim the cream for the not-for-profit hospitals, unless costs and quality are equal or they offer something better. This rarely has been my experience. We then would return to the ethics of Hippocrates, and the only profit made off the sick would be for the actual care the physician himself rendered.

If the physician pays what he owes, if he goes back to his old standard of effort, then we will see in the future that the romance will be back in the affair, the trustees will be more relaxed and have more fun, the administrators will be seen to smile again from time to time, government will have more money, and we will have a kinder, gentler, more ethical America. Hippocrates' bones will rest, the flower of our civilization will regain its fragrance, and, most important of all, the patient will be healthier and happier. ■

MAG Adopts Model Medical Staff Bylaws

Richard H. Vincent, Robert N. Berg and Susan C. Atkinson

At its June, 1990, meeting, the Board of Directors of the Medical Association of Georgia adopted Model Medical Staff Bylaws (the "Model Bylaws"). The Model Bylaws, which ultimately are intended to be distributed to local medical societies and hospital medical staffs throughout the State, represent the final work product of a concerted, lengthy effort by the Hospital Medical Staff section of the Medical Association, working in conjunction with our law firm, to provide an internally consistent, physician-oriented document, describing the relationship between a hospital governing body and its medical staff and setting out rules for the day-to-day operations of the medical staff. In this month's Legal Page, we review some of the more unique features of the Model Bylaws. (For the remainder of this article, the governing board or body of the "owner" of the hospital — the Board of Directors or Board of Trustees — will be referred to as the "Governing Body"; the medical and professional staff of the hospital will be referred to as the "Medical Staff.")

MAG's Primary Objectives in Creating the Model Bylaws

First, to provide some context within which to consider the Model Bylaws, it may be useful to highlight the primary objectives sought to be achieved by the Medical Association in developing a set of Model Bylaws:

- To provide a workable, comprehensive, and internally consistent vehicle for the establishment, governance, and day-to-day operations of the Medical Staff.
- To strengthen the relationship between the Medical Staff and the Governing Body by acknowledging legitimate differences of concern and encouraging cooperative efforts to resolve those differences.
- To comply with all legal requirements, under Georgia and Federal law, as well as with all requirements imposed by the Joint Commission on Accreditation of Health Care Organizations ("JCAHO").
- To provide basic fairness, both to all applicants for Medical Staff membership and clinical privileges, as well as to all members of the Medical Staff.
- To provide Georgia physicians with an alternative to the typical form medical staff bylaws offered by hospitals and hospital attorneys, which usually resolve controversial issues in favor of the Governing Body, rather than the Medical Staff.
- Perhaps most importantly, to utilize its significant experience, as well as that of its members, to propose solutions to novel, difficult and controversial problems.

Ultimately, the true test of whether the Medical Association succeeded in meeting these objectives will come when the Model Bylaws are considered (and hopefully adopted) by Medical Staffs throughout the State.

"The Model Bylaws represent the product of a concerted effort by the Hospital Medical Staff section of MAG and legal counsel to provide an internally consistent, physician-oriented document, describing the relationship between a hospital governing body and its medical staff and setting out rules for the day-to-day operations of the medical staff."

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Unique Features of the Model Bylaws

The Model Bylaws differ in a number of significant respects from the current governing documents of most Medical Staffs in Georgia, for a number of reasons: New statutes have been enacted, imposing further requirements on hospital Governing Bodies and Medical Staffs; recent case law has served to create or modify legal principles relating to liability, disclosure of confidential information, etc.; and, the basic relationship between the Governing Body and the Medical Staff is changing, as hospitals and physicians — together and separately — are involved in joint ventures and other "off campus" aspects of the provision of health care services.

"The Model Bylaws differ in a number of significant respects from the current governing documents of most medical staffs in Georgia."

Briefly highlighting the most unique features of the Model Bylaws:

Use of Hospital Facilities. In the past, Governing Bodies have attempted to circumvent the need to provide due process to physicians (primarily radiologists, pathologists, anesthesiologists, and other hospital-based physicians), by restricting those physicians' use of hospital facilities, equipment, and staff. In the typical case, the Governing Body would argue that the medical staff membership and clinical privileges of the physician were not adversely affected by the Governing Body's decision to extend *exclusive* use of certain facilities to some other physician or other physicians. Usually, the success or failure of this depended on the facts in each case, as well as on the specific wording in the Medical Staff Bylaws. In several cases, courts found that the Governing Body's decision *did* adversely affect the physician's privileges, and therefore could not be undertaken without first providing the physician with notice, a hearing, and other due process rights.[1]

The Model Bylaws deal with this potential problem by defining "Clinical Privileges" to mean not only the "duty or permission to independently provide direct patient care services within well defined limits, based on the individual's professional license, experience, demonstrated competence, ability, and judgment," but also to include the "full right of access to those hospital resources, equipment, facilities, and personnel reasonably necessary to effectively provide patient care services." This definition should preclude a Governing Body from attempting to circumvent the due process provisions of the Medical Staff Bylaws by restricting access to facilities, in lieu of attempting to revoke clinical privileges or medical staff membership.

Model Bylaws as a Contract. Another Governing Body tactic often aimed at Medical Staffs involves attempts by the Governing Body *unilaterally* to modify the terms of the Medical Staff Bylaws. Under the Model Bylaws, this could not be accomplished, as it is specifically stated that the Model Bylaws "constitute part of the contractual relationship existing between the Hospital and the Staff Members, both individually and collectively." The Model Bylaws go on to preclude unilateral amendment by the Governing Body.[2] The contractual nature of the Model Bylaws also means that the failure to comply with its provisions could result in a breach of contract claim by a person injured as a result thereof.

"The Bylaws contain a unique, detailed dispute resolution mechanism designed to deal with situations where the governing body of the hospital and the medical staff disagree on a wide variety of decisions."

Hospital Contracts Affecting Medical Staff Membership and Clinical Privileges. Traditionally, Governing Bodies have felt that contracts between the hospital and individual physicians or physician groups, or for outpatient ventures, were exclusively the province of the Governing Body, without any required input from the Medical Staff. Although members of the Medical Staff typically disagreed with this position, the Medical Staff Bylaws generally provided no basis for any such input by the Medical Staff. The Model Bylaws deal with this problem by specifically giving the Executive Committee of the Medical Staff the right to provide written comments to the Governing Body, concerning the impact which such contract may have on the

overall quality of health care services at the Hospital. This allows a quality of care element to be injected into what otherwise were viewed as economic decisions by the Governing Body.

Consent to Chemical Dependency Testing. The Model Bylaws provide that each applicant for medical staff membership and clinical privileges, by submitting an application, "consents to a chemical test or test of blood, breath, urine, and other bodily substances for the purpose of determining alcoholic or other drug content of his or her system, and consents to a psychiatric or other medical evaluation for the purpose of determining his or her ability to render or participate in patient care, where such tests or evaluation are requested at any time during the application process by [certain persons or committees designated in the Model Bylaws]." This is a provision which is starting to be found, in some form, in more and more Medical Staff Bylaws, as Governing Bodies and Medical Staffs seek out ways to deal with the many difficult issues involved in situations involving impaired physicians.

Medical Staff Aid Committee. The Model Bylaws call for the creation of a Medical Staff Aid Committee, designed to improve the quality of care and the promotion of competence among members of the Medical Staff. Among other things, the Medical Staff Aid Committee is charged with responsibility for developing a written impaired physician policy which addresses appropriate intervention, revocation of clinical privileges, follow-up assessments, and reinstatement of clinical privileges for impaired physicians; receiving reports relating to the mental or physical health, well being or impairment of any Medical Staff member; investigating reports to the extent necessary; requesting chemical testing or testing of blood, breath, urine, or other bodily substances, under certain circumstances; and, generally, studying matters relating to the general health and well being of the Medical Staff and developing educational programs. Traditionally, these functions have been spread out among a number of Medical Staff Committees, or ignored completely.

"The definition of "Clinical Privileges" in the Model Bylaws should preclude a hospital governing body from attempting to circumvent the due process provisions of the Medical Staff Bylaws by restricting access to facilities, in lieu of attempting to revoke clinical privileges or medical staff membership."

Dispute Resolution Mechanism. The Model Bylaws contain a unique, detailed dispute resolution mechanism designed to deal with situations where the Governing Body and the Medical Staff disagree on a wide variety of decisions, relating to Medical Staff membership or clinical privileges, cost containment issues, utilization review issues, employee performance issues and, generally, the quality of health care services rendered at the Hospital. The dispute resolution mechanism consists of several steps, commencing with a request for resolution by the Medical Staff or the Governing Body, and continuing through informal efforts by a Joint Conference Committee (consisting of an equal number of representatives from the Medical Staff and the Governing Body), mediation and arbitration.

Conclusion

Medical Staffs throughout the State will have the opportunity to use the Model Bylaws as a basis for adopting specific Medical Staff Bylaws, providing for their governance and for the relationship between the Medical Staff and the Governing Body. The Model Bylaws are not intended to be an end-product, simply to be adopted by each Medical Staff. Rather, the Model Bylaws are intended to be a starting point, to aid in discussions among the members of each Medical Staff and to guide the Medical Staff in dealing with the many complex issues involved in connection with the governance of the Medical Staff and the relationship between that Staff and the Hospital. Used in this manner, the Model Bylaws can be an invaluable tool in maximizing the quality of health care services rendered in hospitals throughout the State.

Notes

1. *See, e.g., Alfredson v. Lewisburg Community Hospital,* _____Tenn. App. _____ (November 8, 1989); *Reno v. East Pasco Medical Center,* No. 87-318 (Fla. Cir. Ct., December 14, 1988).
2. Existing case law in Georgia *implies* that the Medical Staff bylaws constitute a form of contract, but there are no cases directly so holding. *See Northeast Georgia Radiological Associates, P.C. v. Tidwell,* 670 F.2d 507, 511 (5th Cir. 1982); *c.f., Pariser v. Christian Health Care Systems, Inc.,* 816 F.2d 1248 (8th Cir. 1987).

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The Current Status of Coronary Artery Balloon Angioplasty

John S. Douglas, Jr., M.D.

"The broader indications for PTCA encompassed sicker patients and some less sick patients in whom PTCA was performed as an alternative to medical therapy."

TEN YEARS AGO, percutaneous transluminal coronary angioplasty (PTCA) was regarded as a therapeutic strategy applicable in only a small percentage of patients with coronary artery disease. Improvements in PTCA catheters, high resolution imaging systems, and growing operator experience have led to a much wider application of this technique than was ever envisioned. PTCA is now performed more frequently than coronary artery bypass graft surgery (CABG) for relief of angina pectoris in patients with coronary heart disease.

Critical issues in determining the place of PTCA in our therapeutic armamentarium include the risk of the procedure and its ability to relieve symptoms and favorably influence the quality of life of the patient, compared to CABG and medical therapy. Although randomized trials are only now being conducted, long-term observational studies have confirmed the efficacy of PTCA. In a landmark series of patients treated by Gruentzig, 133 patients had successful PTCA with no procedural deaths, and on long-term follow up for up to 8 years, 68% were asymptomatic and only 5 late cardiac deaths occurred. Restenosis was observed in 30% of patients and necessitated CAGB in 19 patients.[1] In a consecutive series of over 400 patients treated at Emory University Hospital in 1981 and followed for 5 years, cardiac survival was 98%, and 85% were asymptomatic at last follow up.[2] Among these patients, 86% of whom had single vessel disease, subsequent repeat PTCA was required in 20% and CABG in 15%. On the basis of these studies and others, PTCA became the treatment of choice for many patients with single vessel coronary disease.

Increased Utilization of PTCA

The introduction of steerable dilation catheters in 1983 and subsequent technologic refinements provided angioplasty operators access to distal coronary artery sites and permitted successful dilatation in the presence of complex anatomy, such as bifurcations, tortuous segments, and in some, total occlusions with no increase in complications. In 1987 at Emory University, for the first time, more patients were referred for PTCA than for CABG. A similar phenomenon occurred nationally, and in 1988 the number of PTCA procedures performed surpassed CABGs. By 1989, over 10,000 PTCA procedures had been performed at Emory University Hospital alone, and this constituted the world's largest single center experience.

The broadened indications for PTCA encompassed sicker patients (complex single vessel disease, multivessel disease, poor left ventricular function) and some less sick patients in whom PTCA was performed as an alternative to medical therapy. In a recent report, the treatment strategy applied in 1981 to patients with newly diagnosed coronary heart disease was compared to that employed in 1988.[3] In 1981, 52% of patients were treated medically, 44% with CABG, and 4% with PTCA, while in 1988, 41% received medical therapy, 28% CABG, and 30% PTCA. Referral of single vessel disease patients to PTCA increased from 11% in 1981 to 46% in 1988. Only 1% of double vessel disease patients underwent PTCA in 1981 compared to 30% in

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1988, while referral of triple vessel disease patients to PTCA increased from 0 to 11%. These changes in cardiologic practice had major implications for health care planners, hospitals and reimbursors, as well as for the patient and his physicians.

In spite of increasing utilization of PTCA in multivessel disease, this stragegy remains somewhat controversial. Several large randomized trials comparing PTCA with CABG in multivessel disease are in progress. The Emory Angioplasty Surgery Trial (EAST) has completed entry of approximately 400 patients, randomized to CABG or PTCA and 1-year follow up data will be available in mid-1991. This will be the first head-to-head comparison of PTCA and CABG.

"In spite of increasing utilization of PTCA in multivessel disease, this strategy remains somewhat controversial."

Limitations of PTCA

The primary limitations of PTCA continue to be arterial occlusion at the time of the procedure, or shortly thereafter, and restenosis. The former occurs in 2-10% of patients and the latter in approximately 30% in spite of massive research efforts directed at its prevention. Both are influenced by lesion and patient characteristics and occur more frequently in the presence of unstable angina and in lesions on sharply angulated arterial segments (bend points). Success rate in total occlusions is approximately 75% for a recent occlusion, but <50% for an occlusion present for >3 months. This inability to successfully treat chronic total occlusions significantly limits use of PTCA in multivessel disease patients, where total occlusions are common.

Patient Selection

By considering factors such as age, symptoms, left ventricular function, and lesion characteristics, it is possible to estimate the probability of PTCA success and the risk of the procedure, and to a lesser degree, predict long-term outlook. In general, patients selected for PTCA have stenoses in one or more coronary arteries that subtend at least moderate sized areas of viable myocardium and have symptoms or signs of myocardial ischemia, or need revascularization because of a high risk coronary lesion (proximal site) or to prepare for major non-cardiac surgery. In some patients, occupation or lifestyle may influence selection of PTCA over medical therapy, especially if the safety of others is involved (policemen, pilots, bus driver, or athletes). In patients who undergo successful PTCA but experience restenosis, the preferred treatment is frequently repeat dilatation which has a very low procedural risk and has been shown to be more cost effective than CABG.[4]

After Bypass Surgery:

PTCA has been used with increasing frequency in patients who have had CABG, but experience a recurrence of angina due to graft failure, or progression of coronary atherosclerosis.[5] Approximately 1500 carefully selected post-CABG patients have undergone PTCA at Emory with <1% mortality and a 2% Q wave infarction rate. In all large series reporting results of reoperative coronary bypass surgery, the risk of these complications has been 3-5 times higher.

"During the past decade, there has been a dramatic increase in utilization of PTCA, which has become safer and more effective, but the inability to treat chronic total occlusion and prevent restenosis limits application of this technique."

Acute Myocardial Infarction:

In the early stages of acute myocardial infarction, direct PTCA is effective in restoring arterial patency in 80-90% of patients. However, because of the logistical problems related to acute PTCA, and the overwhelming evidence that intravenous thrombolytic therapy improves survival, the latter strategy has become the initial treatment of choice in most patients with acute myocardial infarction. There is general agreement however that angiography and PTCA are indicated in patients who (1) have persisting ischemia in spite of thrombolytic therapy (reperfusion failure), or recurrent ischemia following thrombolytic therapy (reocclusion) or inducible ischemia by stress testing at 5-7

days post infarction, or (2) present in cardiogenic shock, or (3) have symptoms compatible with acute infarction, but conditions which prevent a definitive diagnosis (permanent pacemaker or left bundle branch block), or (4) present at a time when immediate coronary angiography and PTCA would be possible. Additional indications might include (5) recurrent serious ventricular arrhythmias in spite of therapy, (6) non-Q wave infarction, and (7) patients who are relatively young or have physically demanding jobs or lifestyles.

PTCA In Inoperable Patients:

Currently, an increasing number of patients are encountered who have disabling symptoms due to myocardial ischemia, but because of coexisting medical problems (cancer, pulmonary insufficiency, etc.) or poor left ventricular function are not candidates for CABG. Cautious intervention with PTCA offers a means of palliation in many of these patients.

Economic Considerations

Cost of medical care is a critical issue, and PTCA appears to have a cost advantage over CABG, even in the presence of multivessel disease. At Emory, the total one-year revascularization costs for 100 consecutive multivessel disease patients undergoing multivessel PTCA was $11,100 compared to $22,862 for CABG.[6] Patients were matched for age, sex, and prior myocardial infarction. Randomized trials, which are currently in progress, will provide important information about longer term costs of PTCA and CABG.

Summary

PTCA and CABG are complementary techniques which provide symptomatic relief for patients with coronary heart disease. During the past decade, there has been a dramatic increase in utilization of PTCA, which has become safer and more effective, but the inability to treat chronic total occlusion and prevent restenosis limits application of this technique.

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MRI UPDATE

Figure 1

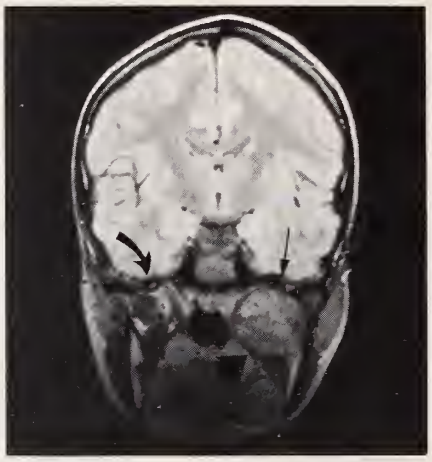

Figure 2

CLINICAL INFORMATION: This is a 14-year-old male with headache and left jaw pain.

FINDINGS: The axial image (figure 1) demonstrates a 4 cm. mass centered in the left parapharyngeal space. It deforms the left nasopharyngeal wall, but the fat plane between the nasopharyngeal wall and the mass indicates that the mass did not arise from epithelium there. The mass extends anteriorly through the pterygopalatine fossa to abut the posterior wall of the maxillary sinus (arrowhead), but it does not appear to invade the sinus. The mass extends laterally adjacent to the neck of the mandibular condyle (large arrow). It is separated from the deep lobe of the parotid by the deep branch of the facial artery. The mass is separated by fat from the internal jugular vein (open arrow). It abuts, but does not encase the internal carotid artery (long arrow). The coronal image (figure 2) demonstrates the mass effect of this large lesion (large arrow). Though the mass lies adjacent to the foramen ovale (small arrow) and appears to engulf an exiting branch of the mandibular nerve, it does not extend intracranially. The mandibular division of the fifth nerve lying just above the foramen ovale is shown on the normal right side (curved arrow).

COMMENT: MRI clearly demonstrates the size and extent of the mass in this difficult location. CT does not provide the multiplanar capability and soft tissue detail afforded by MRI which provides complete presurgical staging and analysis. The differential diagnostic possibilities must include juvenile angiofibroma because of the patient's age and sex. Paraganglioma and schwannoma were also considered possibilities. Mixed tumor arising from the deep lobe of the parotid could produce this appearance, but the lesion appeared to be separate from the deep lobe. The biopsy diagnosis was "sarcoma". Rhabdomyosarcoma in this area more commonly occurs in younger children.

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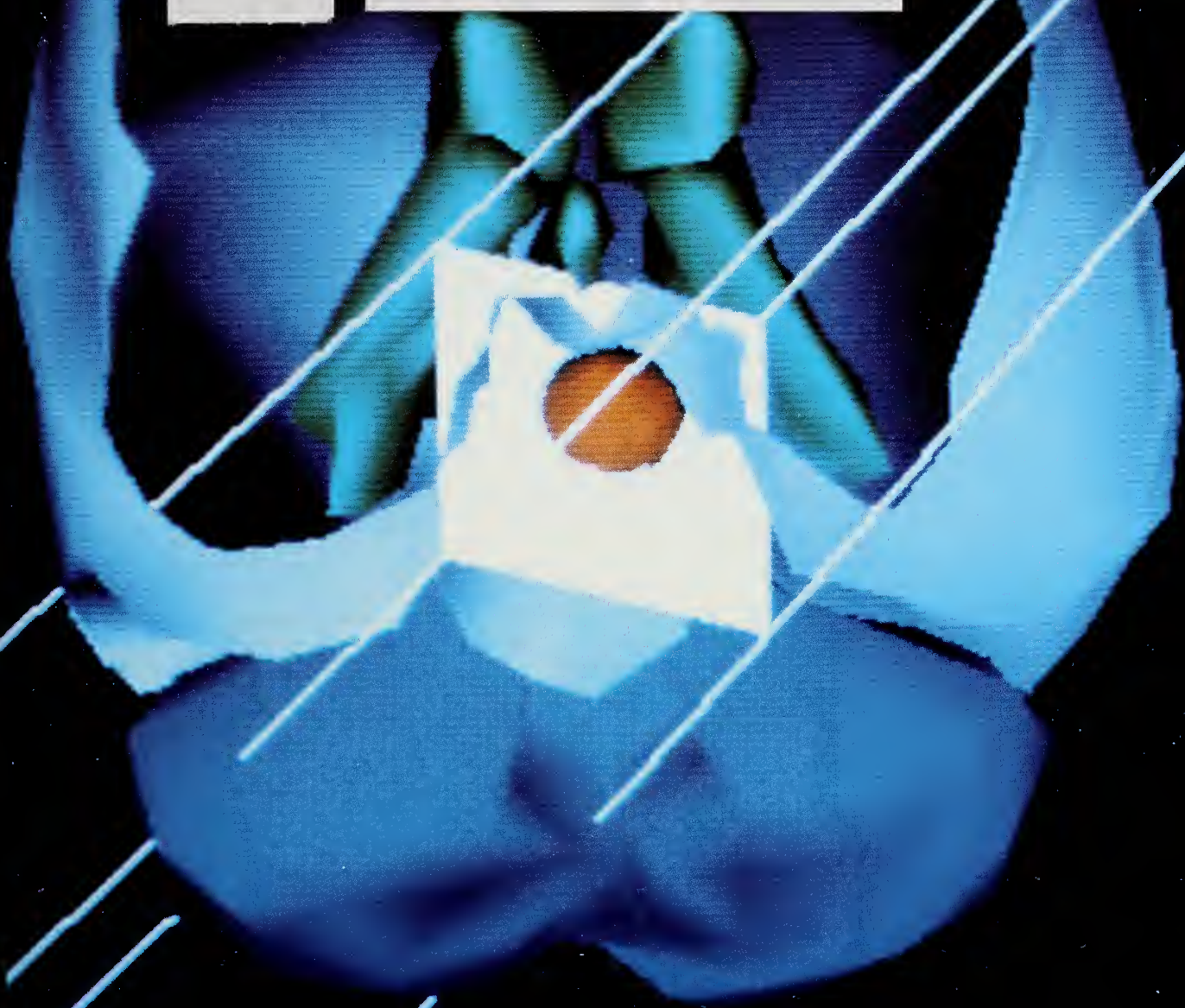

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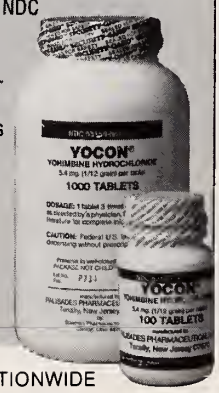

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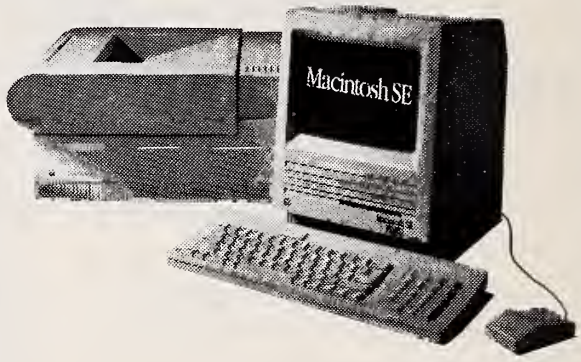

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THE COVER

The image on the cover is a three dimensional CT scan of the human brain. The lines indicate precise placement of the linear accelerator beam to the tumor.
Cover photograph by Howard Sochurek, of Delray Beach, Florida.

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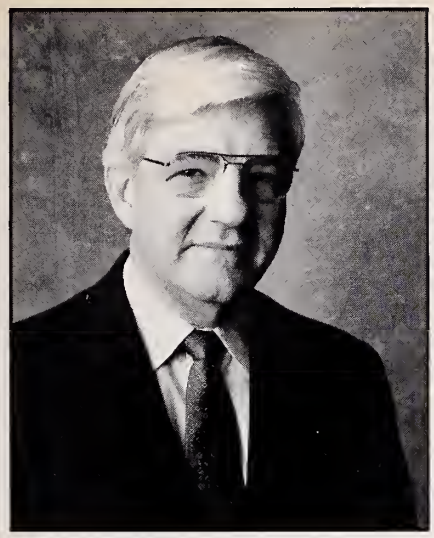

William C. Collins, M.D.

American Medicine — A Unique System For a Unique People

For over 400 years, we have been gathering from the four corners of the earth to join with those native inhabitants of this vast land to create the country that we now call our homeland — the United States of America! Some of us came willingly, some of us came unwillingly, but by whatever route, for the here and now, we are here by choice. As of this moment, anyone who doesn't feel this is the place for him, or his family, is free to immigrate to whatever country will accept them.

Our origins are different, but our futures will be similar for we are bound together in a common destiny. I strongly disagree with the journalistic fad of designating each racial or ethnic group with his or her prefix such as Afro-American, Irish American, Chinese American, etc., etc., etc. For heaven's sake, if this is carried to the ultimate extreme, we will all have a prefix, even our Native Americans. I reiterate — whatever circumstances led to the appearance of our forefathers upon these shores, we are all now unadulterated, reconstituted Americans — we will succeed or we will fail as Americans!

We are a unique people in a unique land — multi-religious, multi-colored, and multi-lingual. We must work together under a common government, salute a common flag, speak a common language, and work for common survival. We must swim together, or we will undoubtedly sink separately.

In this unique land, I submit that we have created a unique medical care system. It is a combination of personal responsibility, charity, and government proviso that have meshed together to provide most people with the quantity and the quality of care they desire. For the unfortunate victim of circumstances beyond their control, there was a safety net of charity and government-sponsored care to provide for them until they could provide for themselves. Self-reliance has always been a cornerstone of the unique American character, and only in recent years have governmental bureaucrats sought to erase this from our common heritage.

We have problems in the American health care system today. There is no denying that. The high cost of advanced technology, malpractice and product liability insurance, increased pay of medical care personnel, a dual free enterprise, para medical system, and extended custodial care outside the home all act exponentially upon our "health care cost." A ward patient at Duke University Hospital in 1930 cost $3. An estimate of a similar 1960 bed would be about $30 and today, if it existed, would be $300. The most noticeable change, then, has been in the past 25-30 years, as it just so happens, with the entrance of the federal government with Medicare and Medicaid into what was a fairly equitable and reasonably priced medical system.

I submit to you that the one thing our unique medical care system does not need is more centralized control and planning, for this is what has brought us to the precipice we now find ourselves upon.

Neither do I think the answers to our problems lie in the importation of another country's system, such as the Canadian or the British, or the French system. We are Americans, and we can solve our problems in the American way — a multi-faceted approach to a multi-faceted problem. Fix the broken parts, and leave the others well enough alone.

Health Access America is the AMA's answer to our current problems of increased health care cost, limited access of care to certain population groups, and increase of government bureaucratic paperwork. Their sixteen point program is a well thought out approach so needed in this time of crisis.

Some of the solutions involve federal legislation, some state, but most all require patient, doctor, and government to work together as a team of problem solvers with the goal of delivery of the quality type of basic care Americans have grown to expect, at an affordable cost to all Americans regardless of income.

I urge each MAG member to get a copy of Health Access America, familiarize yourself with it, discuss it with your patients, your friends and your legislators.

Let's solve our health care crisis the old fashioned American way! Let's work together.

(For copies of Health Access America, write MAG.)

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Elaine Bossak Feldman, M.D., an internist from Augusta, received the 1990 Goldberger Award in Clinical Nutrition at the meeting of the AMA House of Delegates last June.

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Zisholtz, Barry M., Urology — Clayton-Fayette — (Active N1) 101 Yorktown Drive, Fayetteville 30214

Mr. Jim Moffett (R) of the MAG is shown here with Dr. Charlie Hollis, Past Chairman of the Southeastern Delegation to the AMA, with the plaque that was given to Mr. Moffett by the Southeastern Delegation at the AMA House of Delegates meeting last June. Mr. Moffett was awarded this plaque in appreciation for his exceptional contribution to the Delegation as its secretary-treasurer.

Mr. Moffett's expertise and tireless efforts on behalf of the Southeastern Delegation has helped it exert a significant influence in determining the direction of the AMA.

STAFF NEWS

Jim Moffett is a special person — special in general, but in particular to MAG and its physicians.

When Georgia was awarded the chairmanship of the Southeastern Delegation to the AMA, we asked Jim to come on board as its secretary-treasurer. We needed his organizational skills, political expertise, familiarity with procedures at AMA, and his friendship with the key members of the AMA staff. We told Jim that we wanted him to make the Southeastern Delegation the most effective voice at AMA. He has done that.

The Southeastern delegation is a consortium of 13 Southeastern states which have agreed to come together to offer a forum in which we of like minds and philosophies can discuss policies, issues, and candidates. We, through these discussions, attempt to form a consensus and thus exert the influence of our states and their views on the direction of the AMA. At this time, the Southeastern Delegation has a membership which represents almost a fourth of the voting delegates of the AMA house.

Jim has organized the executive committee of the Southeastern Delegation so well that is meets regularly, either in person or through telephone conferences, about eight times each year. Usually a consensus can be reached. There has developed within this group a feeling of sincere respect for each other and a degree of harmony which has made us almost like family.

The most recent dramatic evidence of the effectiveness of the Southeastern Delegation was in the election of Dr. Douglas Skelton, Dean of Mercer, as a member of the prestigious Council on Scientific Affairs. This is the first time in anyone's memory in which a non-delegate such as Dr. Skelton has been able to garner the necessary support to be elected when offering for the first time for a major AMA council. This would not have been possible without the unity and intensive effort of members of the Southeastern Delegation.

The 26 members of the executive committee of the Southeastern Delegation, in recognition and acclaim of Jim's very important contribution to the efforts of this group, made a formal presentation at the general breakfast meeting of the general membership of the Southeastern Delegation at the annual AMA meeting in June. He was presented a plaque as a symbol of appreciation from this group.

This is another example of the way in which Jim Moffett has represented MAG well and brought recognition and prestige to those who represent Georgia at the AMA.

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CRAWFORD W. LONG, M.D.

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at Jefferson
Jackson County, Georgia
U.S.A.
Born at Danielsville, Ga.
November 1, 1815
Died at Athens, Ga.
June 18, 1878

"My profession is to me a ministry from God."

Such greatness from such an ordinary little town, I thought to myself. But now, as I was saying about the patient.

Soon after that visit to my office came the call from the attorney. She was going to sue, to initiate litigation against the original physician. And I, in all my innocence, was to be an "expert." "Must I do this?," I asked this plaintiff's attorney. "I merely confirmed the diagnosis, participated none at all in the treatment. I am no hired gun. There are such, I will give you their names. Or you can look them up in your little 'black book.' They will say what you want them to. But me, I am only an innocent bystander." I pleaded for time to plan my escape from the treachery. A brief respite was granted and with it I consulted my own legal guardian and comforter, my professional liability carrier. "You have a professional relationship with the patient," I was told. "And that relationship carries over into the legal engagement. You must testify as to what you saw, as to what you thought when you saw this patient."

And so it was that I found myself at the little county courthouse that morning. Found myself in the company of Crawford W. Long, M.D. Found myself ascending the witness stand, raising my right hand and swearing to the "truth." "Your name, your location, your training, your charges," they asked. "Your charges," they had asked on another occasion, "were they reasonable?" "Yes, I think so, especially in view of the light that after 3 years they have not been paid." No escaping now.

"You are here to testify for the plaintiff, I understand," began the defendant's attorney.

"No sir," I said, "I am not here to testify for or against anybody. I am here to help you find the 'truth' in this matter." They seemed a bit taken aback. As I stepped from the witness stand, the kindly judge, for so he was, called after me. I shuddered. What affront, what breach of legal etiquette had I engaged in?

"Doctor, we want you to know that this is the birthplace of Crawford W. Long. We are proud of him. There is a statue out front."

"Yes, I know, I have already had my picture made with him." The judge, the twelve tried and true jury, smiled.

'I am not here to testify for or against anybody. I am here to help you find the "truth" in this matter.'

I found myself once again on the two lane asphalt road leading me now away from Danielsville. Time now for reflection upon the day. Had there been any way out of this less than entertaining legal excursion? A way to have remained in the security of my familiar and unthreatening office? I thought not. It is a necessary and important aspect of our professional lives. We must be a part of it. A participant. After all, there is the clear warning, "There but for the grace of God, go I." Are they, the attorneys, the judge, the jury, are they each and all looking for "truth" as I in all my

legal innocence had thought them to be? Or was it simply a game, a treacherous and costly game played with rules devised unilaterally, ever changing rules, with the prize falling to the crafty. I doubted not that day the innocence of those involved, though the ability of the twelve "tried and true" to grasp technical intricacies upon which rested the decision seemed in question. But does that level of integrity abide in all such courts? My doubts persisted.

One final threat seemed clear to me, and it is this. Through the office doors of each of us, every day of our future lives, will walk a great array of individuals seeking our help, our advice, our ministrations. They will present to us a wide variety of personalities and temperaments. Some will trust us. Others will doubt us. Still others will actually confront or challenge us. They will all test us in one manner or another. We must not fall prey to the pervasive and self-destructive tendency nurtured by a threatening and unpalatable legal environment to see these people who seek our help as a potential plaintiff rather than as a patient in need of our services. Certainly reason and caution must abide, but they can only rest within the bounds of a compassionate and intelligent and organized medical practice. It is risky business we are engaged in but that risk must be understood and managed and controlled else it destroy us and those who trust their health and their welfare to us.

CRU

QUOTES

Great men are not always wise.

JOB XXXII, 9, C, 325 B.C.

The man of greatness never loses his child's heart.

MENCIUS
Discourses, IV, c. 300 B.C.

Oh, that my tongue were in the thunder's mouth!
Then with a passion would I shake the world.

SHAKESPEARE:
King John III, c. 1596

We went to Mannheim and attended a shivaree — otherwise an opera — the one called "Lohengrin." The banging and slamming and booming and crashing where something beyond belief.

S. C. CLEMENS (MARK TWAIN):
A Tramp Abroad, IX, 1879

One pain is lessen'd by another's anguish;
One desperate grief cures with another's languish.

SHAKESPEARE:
Romeo and Juliet, I, c. 1596

If all men defined "honorable" and "wise" alike there would be no debate on earth. As it is, each man defines these words, for himself, and only the names remain unchanged.

EURIPIDES:
The Phoenissæ, c. 410 B.C.

The first advice of a woman is always the best.

FRENCH PROVERB

In vain the sage, with retrospective eye,
Would from th' apparent what conclude the why,
Infer the motive from the deed, and show
That what we chanced was what we meant to do.

ALEXANDER POPE
Moral Essays, I (Of the Knowledge and Characters of Men), 1733

Nature never intended man to be a low, grovelling creature. From the moment of his birth she implants in him an inextinguishable love for the noble and the good.

LONGINUS:
One the Sublime, XXV, c. 250

Mankind are very odd creatures: one half censure what they practise, the other half practise what they censure; the rest always say and do as they ought.

BENJAMIN FRANKLIN
Poor Richard's Almanac, 1752

Our sex's weakness you expose and blame,
Of every prating fop the common theme;
Yet from this weakness you suppose is due
Sublimer virtue than your Cato knew.
From whence is this unjust distinction shown?
Are we not formed with passions like your own?
Nature with equal fire our souls endued:
Our minds as lofty, and as warm as our blood.

MARY WORTLEY MONTAGU:
Letter to James Stuart, July 19, 1759

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Untimely Diagnosis of Breast Cancer — Everyone Loses

Philip A. Israel, M.D.

THE FAILURE to diagnose breast cancer in a timely manner has led to an avalanche of lawsuits against physicians. The frequency of these lawsuits can be explained by the nature of breast cancer, which is very common among American women, occurring in approximately 10 percent of the female population.

Breast cancer is a tumor very frequently associated with a delay in diagnosis which might result in death or cosmetic disfigurement. It can be difficult to detect by palpation and x-ray when the tumor is small or when the breast is generally lumpy because of fibrocystic mastopathy. A variety of different medical specialists are responsible for diagnosing breast cancer, including family practitioners, internists, and gynecologists. In none of these groups is breast care the primary responsibility.

Improper use of mammography has also contributed to the increase in lawsuits. Some physicians are not aware of the guidelines for mammography or they choose to ignore the guidelines. False confidence as a result of negative mammograms can delay the treatment of breast cancer even when the patient has a palpable breast mass.

Lawsuits against physicians for the untimely diagnosis of breast cancer were analyzed by a national association of physician-owned malpractice insurance companies, the PIAA, and the findings were reported at the association's annual meeting in May, 1990. The study reviewed 273 paid claims reported by 21 member companies of the association, including MAG Mutual Insurance Company. Breast cancer is most common in older women, but 70% of the lawsuits involved patients under age 50. Most of the breast lumps, 69%, were discovered by the patient but not fully appreciated by the examining physician, resulting in a delay in referral for a biopsy. In 49% of these cases of breast cancer, the mammogram was negative or inconclusive. The most common physician specialty named in the claims was OB/GYN (135), followed by family practice (60), surgeons (57), internal medicine (42), and radiology (40).

The most common problems initiating lawsuits with regard to breast cancer are:

1) The failure to order baseline mammograms and follow-up mammograms.
2) Failure to refer patients with breast problems for surgical consultation.
3) Failure to perform thorough breast examination and to record all of the positive *and* negative findings.
4) Failure to instruct patients in breast self-examinations.
5) Failure to investigate palpable "lumps" when mammograms are said to be "normal."
6) Failure of abnormal mammogram reports to be identified by the doctor and his staff leading to delay in notification of the patient.

'Breast cancer is more common in older women, but 70% of the lawsuits involved patients under age 50.'

Lawsuits can be prevented or at least successfully defended if physicians will take a complete breast cancer risk factor history and record all answers, preferably with the use of a printed questionnaire. The risk factor history will determine the necessary frequency of mammography and follow-up physical examinations.

Dr. Israel is a general surgeon, specializing in diseases of the breast. His address is 702 Cherokee St., Marietta, GA 30060.

Physicians should avoid inflexible reassurance to patients regarding diagnostic accuracy or therapeutic results. Do not promise more than can be realistically expected. Do not offer absolute reassurance, such as "stop worrying, you don't have breast cancer." Use all diagnostic modalities when evaluating breast masses, including mammograms, breast self-examination, and a thorough physical examination with the patient sitting and lying down. Invasive diagnostic procedures such as needle aspiration biopsy of solid lesions and cyst aspirations should be avoided by non-surgeons engaged in breast screening. Make all referrals in a timely manner, avoiding long delays.

'Never ignore a woman's complaint about her breasts, even when the physical examination reveals no apparent pathology.'

Take the time to educate patients on the limitations of mammography and physical examination, both modalities being less than perfect in detecting breast cancer. Never ignore a woman's complaint about her breasts, even when the physical examination reveals no apparent pathology. Evaluate the breast with mammography, instruction in breast self-examination, and arrangements for follow-up office visits. Always be aware of the possibility of an occult neoplasm, even in a patient with no suspicious lumps and a normal mammogram. Be cautious. Practice quality medicine and be aware of risk management techniques.

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Medicaid Voluntary Contribution Program Begins

IMPLEMENTATION of the Indigent Care Trust Fund is under way, with 58 "disproportionate share" hospitals in Georgia eligible to participate in the voluntary contribution program which seeks to raise additional Medicaid monies.

An estimated $94 million will be generated this year from the $36 million in voluntary donations made to the trust fund, according to Joseph A. Parker, Georgia Hospital Association president.

Legislation that passed the 1990 General Assembly created a mechanism for activating the trust fund which was established by previous legislative action. HB 1696 was drafted this year to assist disproportionate share hospitals with their heavy indigent care loads by empowering the Georgia Department of Medical Assistance (DMA) to establish rules and regulations for voluntary contributions to the state's Indigent Care Trust Fund.

The contributions will be matched almost 2-1 with federal funds, in the same manner that state monies budgeted for Medicaid are matched under current federal law.

Each participating hospital will contribute to the trust fund based on the number of its Medicaid admissions, and, in turn, will receive a pro rata share of the funds returned.

"The implementation of this trust fund is a tremendous help to those hospitals that see more than their share of Medicaid patients and, in most cases, are not adequately compensated for services rendered," Parker said.

"It is also very good news for the people of Georgia, since continuation of the trust fund will mean expansion of Medicaid eligibility for pregnant women and children, as well as extended services and implementation of primary health care programs," he said. "The Department of Medical Assistance deserves much of the credit for establishing a workable and reasonable vehicle for obtaining additional Medicaid funding."

Incentives for participation ensure that virtually all funds donated will be returned to contributing hospitals for designated services. In the event that the funds are determined to be ineligible for federal matching monies, the contributions also will be returned.

"The regulations were written to protect the contributors," according to Cal Calhoun, GHA's director of financial services. "There is little risk of losing any money, even if the program is terminated."

The Health Care Financing Administration (HCFA) has proposed a rule linking federal Medicaid contributions solely to general state expenditures. Unless Congress acts to prohibit HCFA from inplementing the rule, it would take effect Jan. 1 when a moratorium against imposting restrictions on state Medicaid funding sources is lifted.

A majority of the Georgia congressional delegation, however, supports legislation that would allow states to continue using provider-specific taxes, or voluntary contribution programs such as Georgia's Indigent Care Trust Fund, to increase federal matching Medicaid dollars.

"Georgia's Medicaid program will benefit significantly from the trust fund's implementation, if only from July through December of this year," Parker said. "But, after talking with various members of our delegation, I am optimistic that this funding mechanism will be allowed to continue past December."

In drafting regulations for activating the Indigent Care Trust Fund, the DMA set forth several conditions for the hospitals' receipt of the payment adjustment. Hospitals must continue to participate in the Medicaid program and comply with DMA rules and requests for reports on the use of funds. That use shall include providing health care services to Medicaid recipients and indigent Georgians without discrimination.

In addition, participating hospitals must use at least 15 percent of the payment adjustment funds for support of primary care services and submit a plan of usage to the DMA no later than Aug. 30 of each calendar year.

Hospitals must continue to provide obstetrical care services if such services presently are provided, and they must advise the public of their participation in the trust fund program. Any payment adjustments made must be returned, if the hospital is determined to have been inappropriately designated a disproportionate share hospital or fails to comply with DMA regulations.

THE PATH TO SCHOOL

School lies a mile before me
Across dew-laden grass,
There petals are for picking
To give some freckled lass.

A path of thoughts worth thinking —
A concentrated mile —
Perhaps the gods are winking;
Perhaps they feel a smile.

As merry bob-whites whistle,
Replying to my call
From elder bush and thistle
About the waterfall.

I look from school with yearning
And hum a wistful tune,
For meadows in the morning
Are never the same at noon!

POSTHUMOUS AWARD

You broke the stillness of the morning air
With whir of sudden flight; an instant there
A glint of gold from autumn-feathered wing!
With quickened pulse that such tense moments bring
I raised my gun — the briefest hesitancy —
Then fired! The echo bounded back to me.
I walked with hastened step to where you lay.
And reached to hold the eager dog at bay.

The ruffled feathers of your russet breast
Were warm and moist, a tribute to the quest.
Your graceful beauty, lying motionless,
Was meant for heights that only it could bless.
Can your award be only my regret
That wishing fails to find you winging yet?

JOHN RANSOM LEWIS, M.D.

Dr. Lewis, a plastic surgeon in Atlanta, is Georgia's Poet Laureate.

Your Soul Lives — In Other People's Minds

Robert M. Webster, M.D.

THE CURTAIN is drawn. All is silent behind it in the bedroom, now a deathroom. The sheet has been drawn up over the body. The Emergency Medical Services have left. The policewoman is making her final report. Relatives sit in the living room with the family pastor. There is discussion as to what funeral arrangements might be made. The family physician advises the gathering to leave the body in the deathroom so the widow can have a few moments alone with him before proceeding with final arrangements.

Two hundred miles away on a rainy night, a car is steadily, swiftly travelling along the Interstate carrying the widow. She has phoned ahead several times to check on her race against death. What are her thoughts? Her husband's soul is with her.

Her husband has been terminally ill for several years. She has cared for him well at home. She took over the business and kept it successful. She has provided care around the clock with regular attendants. There have been several previous close encounters with death, but the merciful sleep never came, until tonight. There was no grim reaper calling; this was a release from prison, for both. His soul comforted her. Where did the soul come from, and go? The soul started before conception when there was a desire for, and thoughts about, a child. It lived in the parents' minds. The soul was augmented by the positive pregnancy test, the signs of life in the mother's womb, and with childbirth. Life and the soul continued.

Is the soul confined within one's body? No. We live and move and have our being. The soul has two parts: the part within, the mortal part, and the everlasting part, the part that lives in other people's minds.

There is no cloud rising from the body at death. There is no weight or mass that can be seen or measured that leaves for parts unknown.

The voice with its timbre, its wit, its love, its business deals is stilled. The twinkle in the eye, the warm hugs, the reassuring physical presence, the action parts are gone. That is the body with its mortal soul.

The immortal soul has come from eternity into our heritage, and as the everlasting soul will go on to eternity. As long as someone somewhere, sometime, somehow thinks of, recollects, is reminded of, or remembers that person, that is the soul going marching on. John Brown's body lies in the grave but his soul goes marching on. When you name "Christopher Columbus" or anyone else, that is his soul going on — to eternity.

So is it with that body now in the death-room. His widow will recall the happy times they have had together, the struggles they endured, their accomplishments, their failures and successes together. The family is gathering as in a wake and will tell stories as they grieve — happy, sad, wistful stories, memories — that is the soul going on.

The paper will have an obituary notice. The readers will recall or be told of the deceased and thereby add to his soul. Photographs will be reminders. The funeral or memorial service will recount the milestones in his life, the recollection—his soul—being alive in their minds.

The agony of the terminal illness and the dying will fade. After death, the pleasant memories, the ultimate soul, will continue to live in his widow's and in other people's minds from here to eternity. Yes, the soul of a person is that part that lives in other people's minds.

Dr. Webster practices internal medicine, specializing in allergy. His address is 2665 Acadia St. (At Cleveland Ave.), East Point, GA 30344.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physicians Recognition Award (PRA) from January through March, 1990.*

The award was established by the AMA House of Delegates in 1968 "To recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review, at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category I credit by organizations accredited for these activities.

We can congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

S. Jeffrey Ackerman, *Atlanta*
Alfredo Alarcon, *Atlanta*
Earl Lewis Alderman, *Atlanta*
Susan Alexander, *Commerce*
Steven Mark Amster, *Jesup*
William Jackson Atha, *Rome*
Ezzat Mofid Aziz, *Augusta*
Roy Arpad Earle, Bakay, *Atlanta*
Phillip Harold Beegle, *Atlanta*
Arnold Joel Berry, *Atlanta*
Allan Bleich, *Atlanta*
Larry Eugene Brightwell, *Columbus*
Harold Jos Brody, *Atlanta*
William Owen Brown, *Moultrie*
Harold Paul Brusman, *Riverdale*
Charles Wesley Butler, *Atlanta*
Teresa Elaine Clark, *Atlanta*
David Arthur Cohen, *Alpharetta*
Teodoro Forcht Dagi, *Atlanta*
Alfonso Tiongson Dampog, *Snellville*
Robert L. Davies, *Decatur*
James Wilson Davis, *Atlanta*
Harry Eugene Dawson, *Rome*
Joseph Michael DeGross, *Moultrie*
Mina Karen Dulcan, *Atlanta*
Miguel Angel Faria, *Macon*
Robert Merril Fine, *Atlanta*
James Patrick Flynn, *Lawrenceville*
Hal Myreon Frederick, *Atlanta*
Leroy Robert Fullerton, *Augusta*
Gilbert Charles Goldman, *Atlanta*
Earl Alwin Grubbs, *Alpharetta*
Ralph Lewis Haynes, *Atlanta*
James Christopher Hays, *Atlanta*
John Helfer, *Evans*
Thomas Glenn Hill, *Decatur*
William Francis Hogan, *Thomasville*
Emory W. Holloway, *Macon*
Mark Jay Holzberg, *Atlanta*
Charles Hardin Hood, *Fort Stewart*
Vendie Hudson Hooks, *Augusta*
Richard Hunter Jennings, *Atlanta*
Linda S. Jones, *Bainbridge*
Richard Bruce Karsh, *Thomasville*
Hyun Hahk Kim, *Atlanta*
Houston Wyke Kitchin, *Clayton*
Somanth G. Kudchadker, *Columbus*
William Keith Lane, *Albany*
Richard Alan Langford, *Dublin*
Rosa Belen Licha-Baquero, *Stone Mountain*
Robert David Marcus, *Columbus*
Thomas Woodrow Marks, *Atlanta*
Sean Francis McCue, *Macon*
John Clay McHugh, *Gainesville*
Donald C. McLean, *Atlanta*
John David Mullins, *Atlanta*
E. Anthony Mussara, *Marietta*
Afolabi Oguntoyinbo, *Augusta*
Hermann Karl Orlet, *Augusta*
Peter Michael Payne, *Athens*
Peter Phillips, *Atlanta*
B. Alfred Pihl, *Atlanta*
Hector Piza-Garcia, *Sparta*
David Thomas Plaxico, *Macon*
Jeffrey Robert Prinsell, *Atlanta*
Thomas Michael Ralston, *Grovetown*
Rafael G. F. Razuri, *Savannah*
Reubean Alvis Reynolds, *Forest Park*
Sava Mathew Roberts, *Augusta*
Wayne Murray Rosen, *Atlanta*
Haresh Mulji Ruparel, *Quitman*
Bruce Andrew Salzberg, *Atlanta*
Meyer Paul Schwartz, *Atlanta*
Herbert Erwin Segal, *Fort Benning*
D. Gamini Seneviatne, *Columbus*
Charles B. Shiver, *Augusta*
Hilton Eugene Smith, *Columbus*
Guy Howard Sommers, *Smyrna*
Oscar S. Spivey, *Macon*
George G. Stebbins, *Clarkesville*
John Richard Stephenson, *Columbus*
William F. Thorneloe, *Atlanta*
Rex Wallace Tidwell, *Macon*
Jerome Pound Tift, *Macon*
Bassam Bachir Tome, *Atlanta*
Howard George Vigrass, *Columbus*
Richard George Wagner, *Atlanta*
Don Cannon Walker, *Newnan*
Bradley Lee Ward, *Taylorsville*
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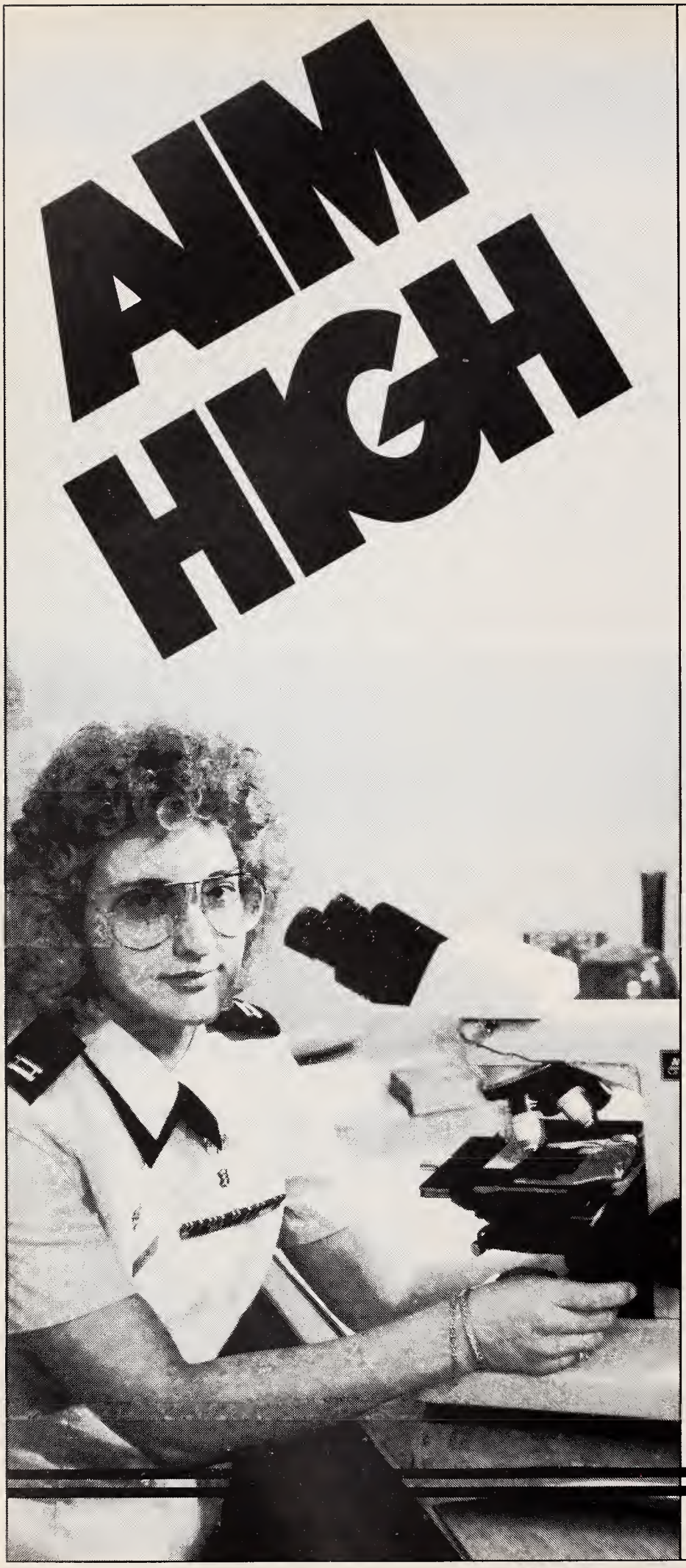

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Stereotactic Radiosurgery

Daniel L. Barrow, M.D., Roy A. E. Bakay, M.D., Ian Crocker, M.D., Patton McGinley, Ph.D., George T. Tindall, M.D.

The Radiosurgical Board (at Emory), composed of neurosurgeons, neuroradiologists, radiation oncologists, and radiation physicists, reviews each patient referred for stereotactic radiosurgery to determine the safety, efficacy, and appropriateness of this procedure as opposed to other treatment modalities.

Drs. Barrow, Bakay, and Tindall are from the Department of Surgery (Neurosurgery), Dr. Crocker is from the Department of Radiologic Oncology, and Dr. McGinley is from the Department of Physics, Emory University School of Medicine, Atlanta.

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Introduction

STEREOTACTIC radiosurgery is a neurosurgical procedure used to treat certain lesions in eloquent or poorly accessible regions of the brain. It involves the delivery, in a single session, of a high dose of ionizing radiation to a stereotactically localized, relatively small volume of tissue. The term "radiosurgery" was coined by Leksell in the early 1950s.[1] Since that time, stereotactic radiosurgery has been used to treat a variety of intracranial lesions that are considered inoperable or that carry an excessive risk with conventional surgical techniques. The most common applications of radiosurgery have been to treat arteriovenous malformations (AVMs) and certain brain tumors, and to create brain lesions for movement or pain disorders. Unlike conventional radiation therapy, stereotactic radiosurgery does not "treat" tissue by taking advantage of a differential sensitivity between tumor cells and normal brain cells. Instead, the technique utilizes a beam of radiation as a tool (much like a surgeon's scalpel or laser beam) to destroy tissue within a sharply defined area.

In the past, stereotactic radiosurgery was available in only a few centers in the world due to the high cost of radiation sources used. In 1974, Larsson et al. proposed linear accelerators (linacs) as a less expensive means for performing radiosurgery.[2] Isocentric linacs are available in all major medical centers in contrast to gamma units or cyclotrons, and they may be used for radiosurgery with only minor modifications or additions.

A reliable stereotactic linear accelerator has been developed at our institution. It is similar to those that have been developed at other centers. The purpose of this article is to discuss the concept of stereotactic radiosurgery, the potential uses and complications, and the available options. Lastly, a few comments will be made about the Emory X-ray Knife.

Radiosurgical Instrumentation

Radiosurgical techniques have as a goal the delivery of a high dose of radiation in a single fraction to a well-defined, small intracranial volume without delivering harmful levels of radiation to adjacent normal tissue. A stereotactic apparatus fixed to the patient's skull with sterile pins is used during neuroradiologic target localization studies (CT, angiography, and/or MRI) and treatment. The precise location of the target is determined in a coordinate system, which is established with respect to the stereotactic apparatus. By knowing the relationship between the coordinate system and the radiation source, one can accurately deliver radiation to the target.

Radiosurgery differs in the following important respects from conventional external beam radiotherapy:

1. Small volumes are treated.
2. A single fraction of radiation is used.
3. The radiation dose is deposited with precision, requiring meticulous care in determining target localization and treatment geometries.
4. Multiple beams entering from numerous points over the surface of the head intersect at a common point. This three-dimensional distribution of beams further reduces the volume of normal tissue receiving moderate doses of radiation. Unnecessary dose deposition outside the target volume is thus minimized creating a high-dose gradient at the target volume.

Almost any stereotactic device can be adapted for target localization and radiosurgery, and a variety of systems have been developed and utilized for this purpose. Each of the stereotactic delivery systems uses one of three different sources of ionizing radiation. Synchrocyclotrons emit beams of heavy particles (protons, neutrons, or helium ions); the Leksell gamma knife uses cobalt-60 as a source of gamma rays (photons); and high-energy medical linear accelerators emit x-rays (also photons). Each system has its particular advantages and drawbacks.

Unlike conventional radiation therapy, stereotactic radiosurgery does not "treat" tissue by taking advantage of a differential sensitivity between tumor cells and normal brain cells. Instead, it utilizes a beam of radiation . . . to destroy tissue within a sharply defined area.

Leksell was the first to use stereotactic radiosurgery.[1] With his device, an intracranial target could be irradiated through a large number of small, stationary portals by fixing a semicircular stereotactic frame at different angles and moving the collimator transversely along the frame. Utilizing 201 sources of cobalt-60, with gamma ray beams intersecting at a common point, the Leksell gamma knife is specifically designed for intracranial radiosurgery. The major advantage of the device is that it has been used to successfully treat a large number of patients. Another advantage is that the unit is commercially available and relatively easy to use. Despite its success, there are several detractors that have limited its widespread use. Being a radioactive cobalt system, the Leksell gamma knife cannot be "turned off" and instead must be extensively shielded. Once the portal shield is opened, the patient receives whole-body radiation until the stereotactic head frame is securely attached to the collimator helmet. The half-life of cobalt-60 is 5.26 years, which necessitates the replacement of the cobalt source every 7 to 10 years. Finally, the radiosurgical system, which is useful only for cranial stereotactic radiosurgery, costs approximately $3.5 million for purchase and installation.

Heavy particle irradiation using protons, helium ions, or neutrons requires a large cyclotron for their producton. In a few sites around the world, cyclotrons have been adapted for stereotactic radiosurgery. In these systems, heavy particulate radiation is used as the ionizing radiation source rather than photons.[3,4] Each takes advantage of the Bragg peak phenomenon, which allows the deposition of a concentrated amount of radiation at the target with a relatively small entrance and exit dose. The major limitation to the widespread use of cyclotrons is their cost (approximately $20 million or more), size, and large number of personnel required for operation.

Leksell initially used x-rays from a linear accelerator (linac) as a radiation source for stereotactic radiosurgery but switched to cobalt because of difficulty keeping the radiation beam aligned on the target during rotation of the linac. The subsequent improvement in linear accelerator bearings now makes it possible to rotate them around a fixed point with great precision.[5-7] By circumventing those problems encountered by Leksell, radiosurgery systems utilizing linear accelerators have been developed and used clinically. This breakthrough offers distinct advantages over the older methods of stereotactic radiosurgery and will markedly increase the availability of the tech-

nique. Advantages include the fact that the units contain no radioisotope but rather accelerated electrons to produce x-rays, thus allowing the unit to be easily "turned off." When not being used for stereotactic radiosurgery, the unit can be used for standard radiation therapy. Because most major hospitals contain linear accelerators, their operation and performance are well understood. The expense of modifying a linear accelerator for radiosurgery is a fraction of that required to purchase and run a cyclotron or Leksell gamma knife.

The technique must be extremely accurate regardless of the method used. Any inaccuracy in localizing the lesion or delivering the radiation may result in serious complications.

Although the Leksell gamma knife and linear accelerator utilize gamma rays and x-rays, respectively, they both emit megavoltage photons as a radiation source. Based upon radiobiologic and physical principles, there is no reason to believe that these different systems should produce different outcomes in similar groups of patients.

Recent reports show that the results of radiosurgical treatment of AVMs with linear accelerators are no different than with the Leksell gamma knife.[5, 6] The linear accelerator may be able to successfully treat larger lesions, however.[8] The highest complete obliteration rate for small AVMs reported to date (92.8% at 2 years) is with a linear accelerator-based system.[5] The reported complete response rates obtained with helium ions and protons are lower. This may be related to patient selection, AVM size, or other factors.

Regardless of which unit is used, there can be no compromise in the mechanical accuracy of the unit nor in the individuals selecting patients, planning treatment, administering radiation,and analyzing results. Mandatory personnel include: 1) radiation oncologists with a knowledge of the principles of stereotactic radiosurgery; 2) neuroradiologists to accurately localize targets from neuroradiologic diagnostic images; 3) radiation physicists to oversee quality control of the mechanical and beam accuracy of the unit; to develop dose distributions; to ensure proper localization; and 4) neurosurgeons with a broad background in the surgery of potentially treatable lesions, stereotactic techniques, and clinical decision-making.

Radiosurgical techniques have as a goal the delivery of a high dose of radiation in a single fraction to a well-defined, small intracranial volume without delivering harmful levels of radiation to adjacent normal tissue.

Indications and Contraindications

Stereotactic radiosurgery is very much a surgical procedure and thus requires the same clinical decision-making process involved in conventional neurosurgery. With an expected proliferation of radiosurgical units, there is a major concern that the techniques may be applied inappropriately. The number of patients for whom radiosurgery is the best treatment is quite small. In fact, the relatively small number of patients who are ideal candidates for stereotactic radiosurgery makes justification of the expense for a gamma unit quite difficult. It is doubtful that any cyclotron will be built solely for use in radiosurgery.

In order to appropriately recommend stereotactic radiosurgery, the physician must have an understanding of the natural history of the disorder, be familiar with the other available options for treatment of the disorder, and be fully aware of the potential complications of each of these treatment modalities. Our approach has been to organize a Radiosurgical Board composed of neurosurgeons, neuroradiologists, radiation oncologists, and radiation physicists. This Board reviews each patient referred for stereotactic radiosurgery to determine the safety, efficacy, and appropriateness of stereotactic radiosurgery as opposed to other treatment modalities.

There are a variety of characteristics of both the lesion and the patient that should be considered in determining the appropriateness of stereotactic radiosurgery.

A desirable characteristic of the lesion is that it be relatively small, preferably less than 3 cm. Larger targets can be treated but may require multiple isocenters. Large treatment volumes may be associated with lower response rates or higher complication rates, depending on the dose selected. Another characteristic of the lesion that would make stereotactic radiosurgery a viable option is location deep within the brain or in an eloquent area where more conventional surgical or radiation therapy would be

considered too hazardous (Figure 1). The lesion should be unilateral and sharply delineated in imaging studies.

Patients considered for radiosurgery must be able to provide informed consent with an understanding of viable treatment options, inherent risks of treatment, as well as risks of the untreated condition. The patients selected for treatment must be awake, alert, and cooperative, with a reasonable life expectancy. Refusal of more conventional surgical therapy or medical contraindications to a surgical procedure would constitute an indication to consider stereotactic radiosurgery.

We exclude patients from consideration for stereotactic radiosurgery if any of the following conditions are present:

1. The lesion is bilateral.
2. The lesion cannot be adequately localized with a neuroradiologic diagnostic procedure.
3. The patient is unable to give informed consent.
4. The patient is uncooperative or comatose.
5. The patient is pregnant.

The most frequent treatment categories have been intracranial arteriovenous malformations, brain tumors, and functional neurosurgery. Our approach has been to use the stereotactic linear accelerator to treat highly selected cases of intracranial vascular malformations and certain brain tumors. Those lesions we would consider treating with the Emory X-ray Knife include intracranial AVMs and intracranial tumors such as acoustic neuromas, meningiomas, pituitary tumors, gliomas, craniopharyngiomas, pineal tumors, and intracranial metastases. It must be reemphasized that the vast majority of patients harboring these lesions are best treated by conventional neurosurgery.

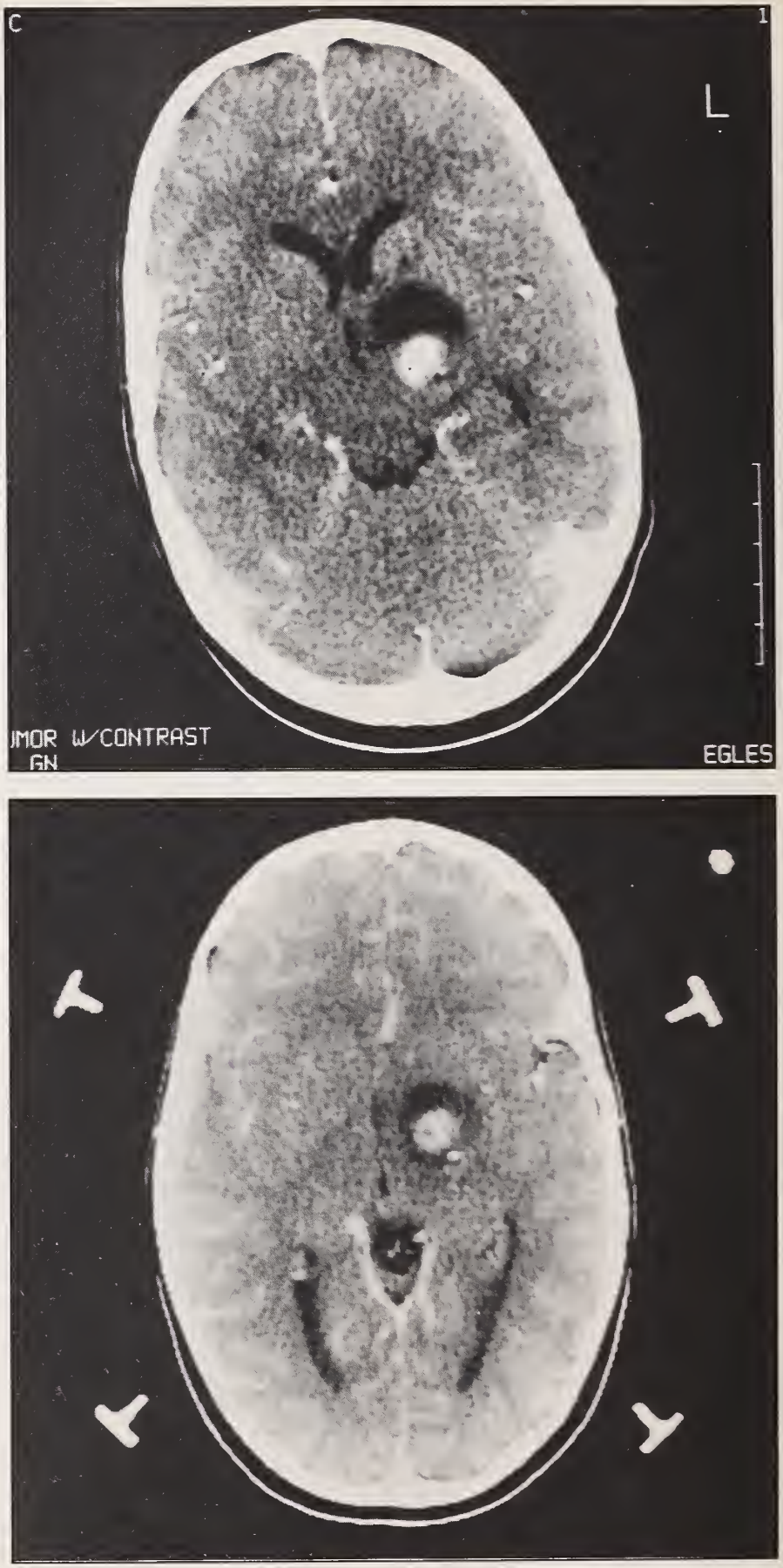
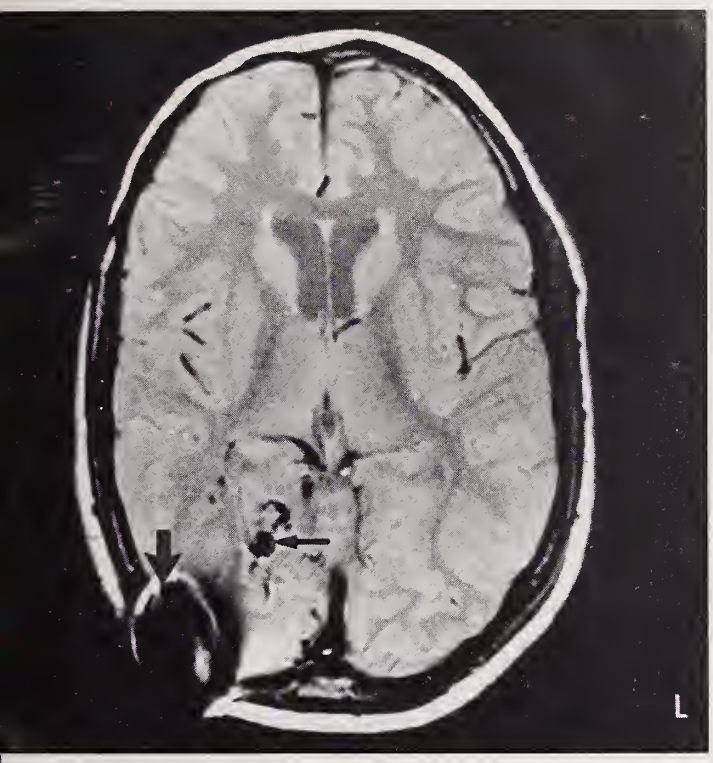
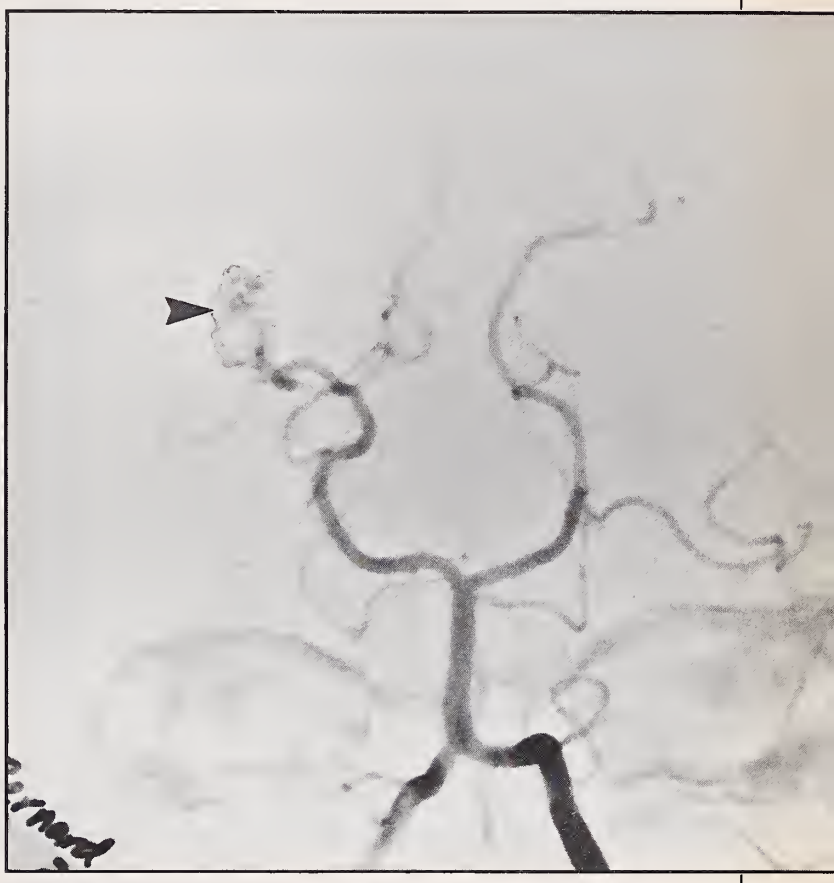


Figure 1. (Top) Axial CT scan reveals well-circumscribed enhancing lesion in the left thalamus with surrounding cyst. Stereotactic biopsy indicated this was an astrocytoma. (Bottom) Axial CT taken at the time of localization for stereotactic radiosurgery. T-shaped marks outside the scan are on the stereotactic frame and serve as reference points for determining the coordinates of the target.





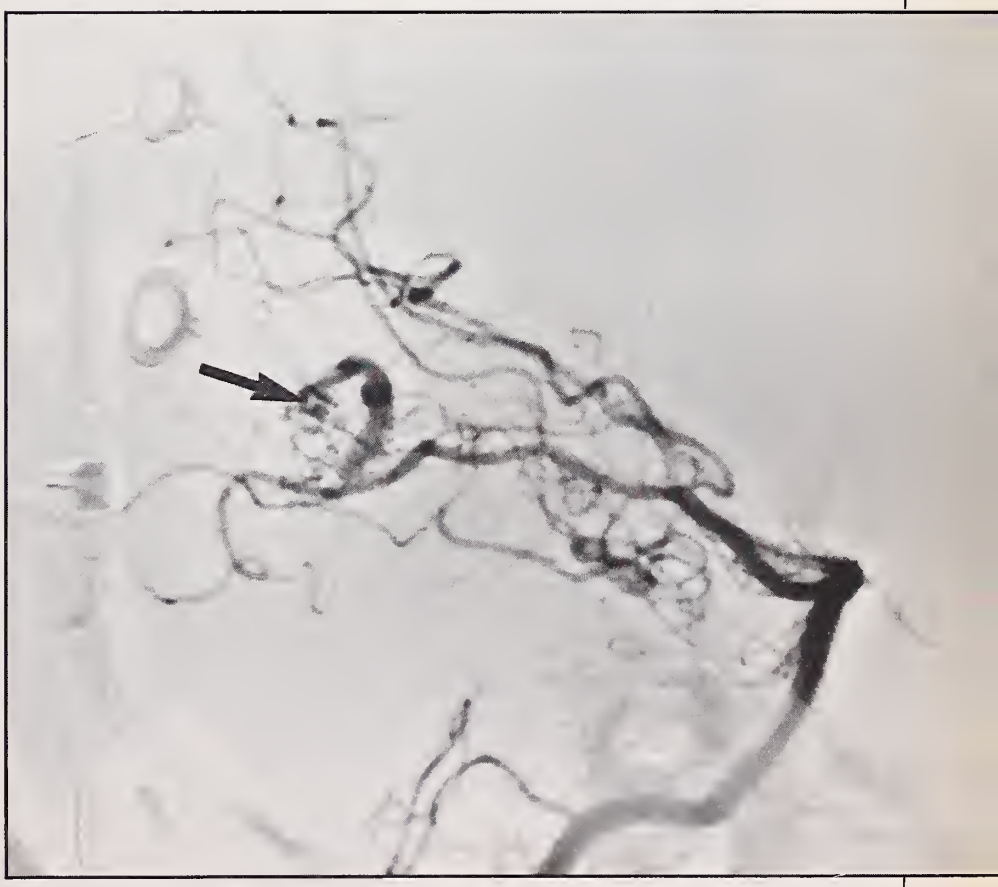


Figure 2. *(Top left) T1-weighted axial MRI demonstrates an abnormal signal void in the right occipital lobe (small arrow). This patient had previously undergone surgical removal of a suprasellar craniopharyngioma and had a ventriculoperitoneal shunt placed for hydrocephalus (note artifact produced by shunt equipment at large arrow). AP (Top right) and lateral (Bottom right) vertebral angiogram shows that the lesion is an arteriovenous malformation (AVM) fed by a branch of the posterior cerebral artery (arrow).*

This patient had a visual field deficit from the previous craniopharyngioma. Because the AVM was within the occipital lobe, we felt that surgical removal of the lesion would put his remaining vision at significant risk. This patient was treated with linear accelerator radiosurgery.

Arteriovenous malformations constitute the largest group of intracranial lesions treated by stereotactic radiosurgery. Managing patients with cerebral AVMs is a complex task requiring knowledge of their natural history, experience with the surgical and endovascular options for treating these lesions, familiarity with the inherent complications of each treatment modality, and skill in clincal decision-making. The great majority of AVMs requiring treatment are best managed with conventional microneurosurgery. Most AVMs can be removed by microneurosurgical techniques with a risk that is below the risk of the natural history of these lesions. The advantage of stereotactic radiosurgery is that the technique avoids an open operative procedure and can be used to treat small AVMs located in deep or eloquent areas where conventional surgery would carry excessive risk (Figure 2).

The great majority of AVMs requiring treatment are best managed with conventional microneurosurgery.

There are several disadvantages of radiosurgery as a treatment for AVMs. The patient must live with the risks of future radiation-induced damage to normal brain. The treatment requires a period of approximately 1 to 2 years to have its effect on the abnormal vessels making up an AVM, during which time the patient is not protected from hemorrhage. The best angiographic obliteration rates achieved with radiosurgery are in the range of 85%. Finally, the cure rate is unacceptably low and risk of radiation greater if the AVM is larger than 2.5-3 cm. The ideal candidate for stereotactic radiosurgery, therefore, is a young patient with a small, deep-seated AVM that has not yet bled (Figure 3).

The Emory X-ray Knife

The Emory X-ray Knife (Figure 4) was developed to carry out certain tasks which are mandatory in stereotactic radiosurgery:

1. The size and location of the lesion must be evaluated.
2. A computerized dose distribution must be produced for treatment planning.
3. Dose levels of several thousand cGy must be delivered to and absorbed by the target volume.

A. Target Localization

Localization of the target volume to be treated is achieved by use of the Brown-Roberts-Wells (BRW) stereotactic system in conjunction with angiography, CT scans, and MRI. A localizer box that can be attached to the BRW head ring allows the coordinates of the target center to be determined. A frontal and lateral angiogram are required for the localization of AVMs. The lesion may also be localized by CT scanning. Small slice separation is required and a total of 30 to 40 slices are utilized. Targets can be localized with an accuracy of 1 mm.

B. Radiation Source

A Siemens Medical Linac is used to produce a 6 MeV x-ray beam for stereotactic radiosurgery. A collimator that attaches to the shield tray holder has been fabricated and is used to produce circular beams with a diameter of 5 to 30 mm in 2.5 mm increments. Extensive beam data have been collected on each collimator for use in treatment planning and dose calculation.

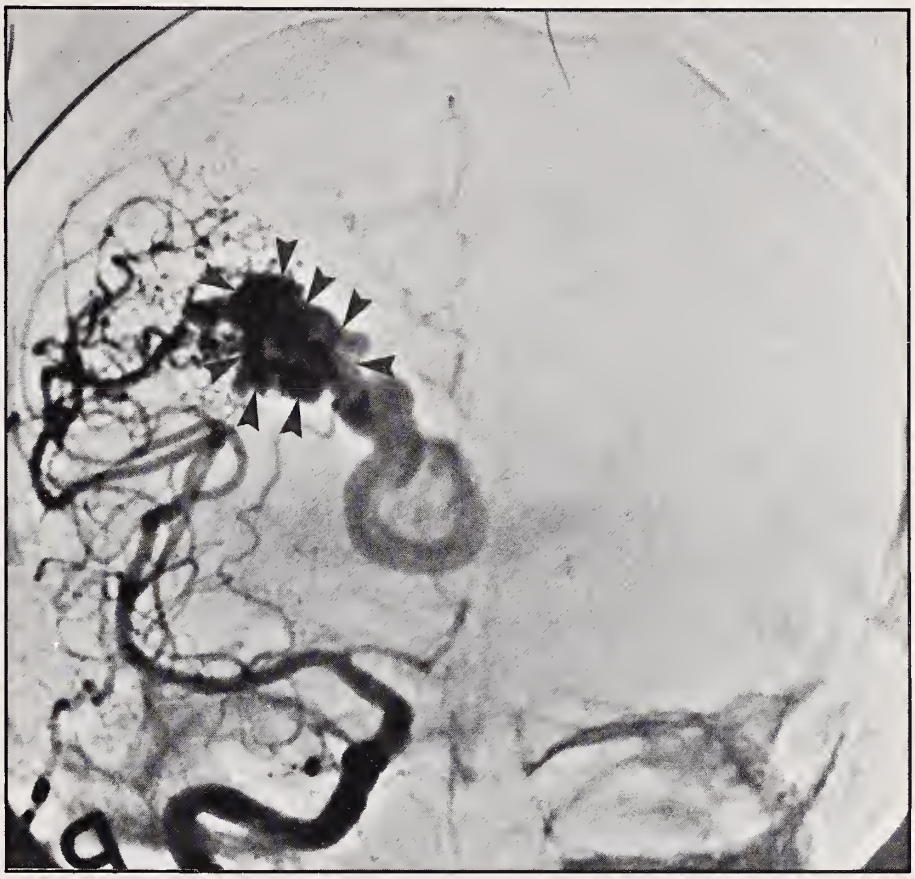
C. Patient Immobilization and Localization

The patient is treated in a seated position on a rotating platform (3-4 RPM) mounted below the x-ray source. A BRW floor stand is also attached to the rotator platform behind the patient chair. The gantry of the linac is rotated to an angle in the range of 35 to 80 degrees with respect to the vertical and with the beam central axis intersecting the rotator axis. This intersection point will be referred to as the apex point. The BRW head ring is attached to the floor stand to fix the patient's head with respect to the apex point. Three orthogonal drives on the floor stand are used to position the ring and patient's head so that the target volume center is at the apex.

The relatively small number of patients who are ideal candidates for this procedure makes justification of the expense for a gamma unit quite difficult.

D. Treatment Planning

A computer program is used to calculate the dose distribution in three planes each containing the target center and used to select the collimator size and gantry angles to be utilized for treatment. The computer system uses contour information measured for the patient as well as the beam data obtained for each collimator. Based on this technique, the uniformity of dose in the target volume and the level of dose in healthy tissue will be evaluated.



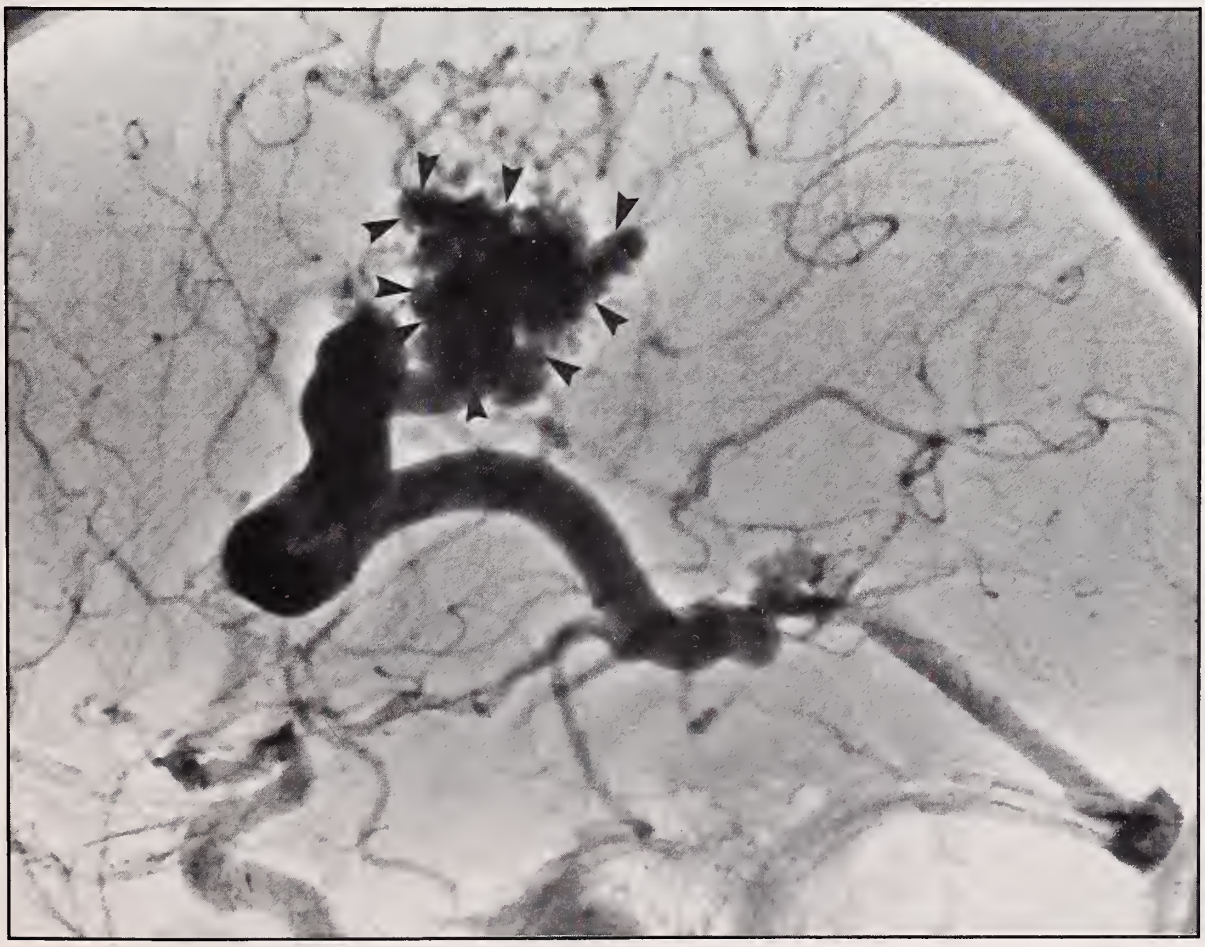


Figure 3. *AP (Right) and lateral (Bottom) right carotid angiogram demonstrates an AVM fed by branches of the middle cerebral artery with deep venous drainage into the Galenic system. The deep location away from any surface of the brain made conventional microneurosurgical excision of this unruptured AVM unappealing. Stereotactic radiosurgery was recommended instead. Although the entire malformation appeared to be quite large on CT, the actual nidus of the AVM (that portion requiring treatment) is under 3 cm (arrows).*

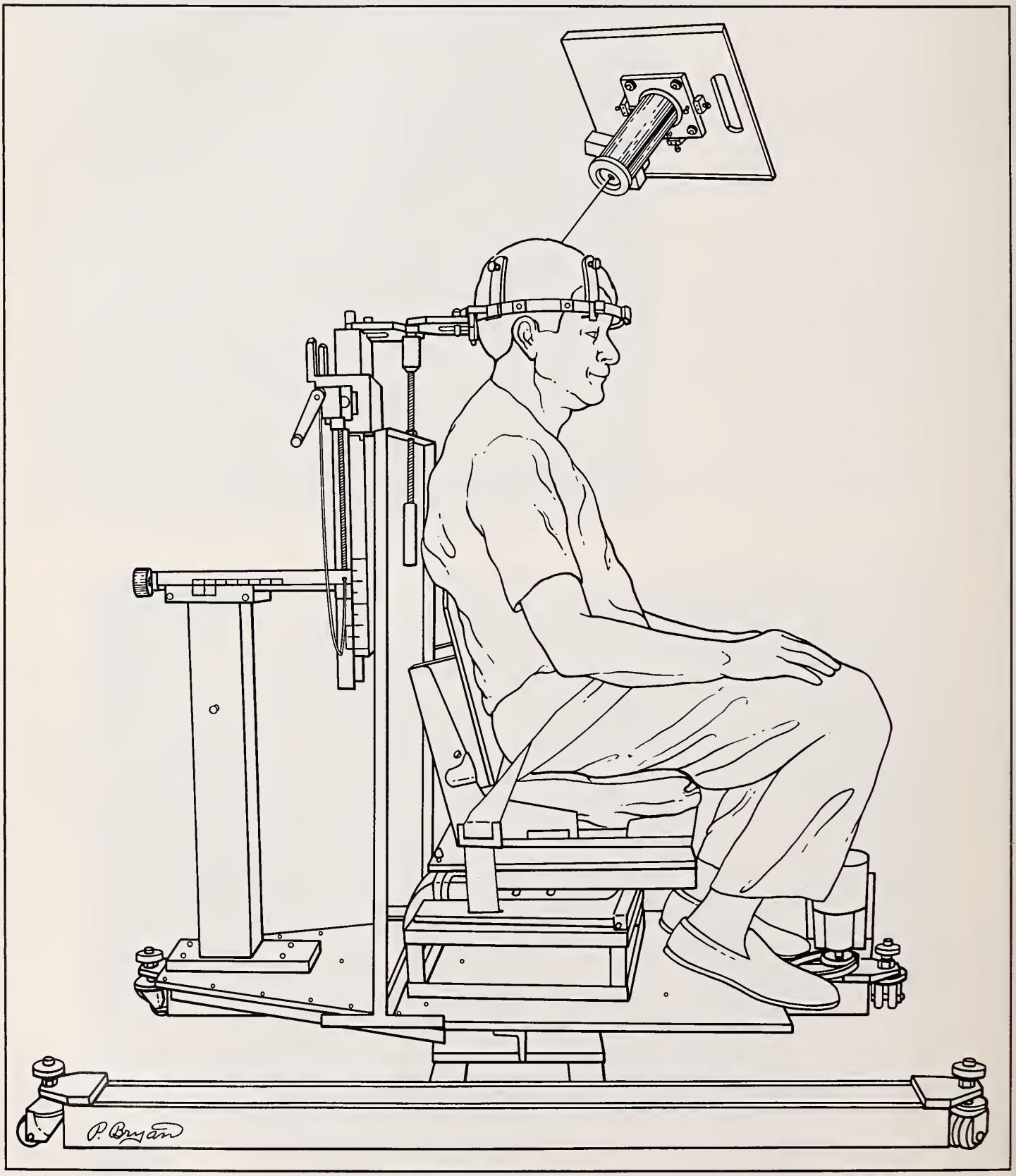


Figure 4. *Artist's rendition of the Emory X-ray Knife. Patient is shown sitting on rotating platform mounted below the X-ray source. The patient's head is held immobile by the BRW head ring attached to a rigid floorstand.*

E. Quality Control

Verification of the alignment of the target center with the apex point is accomplished by making radiographic exposures with the linac x-ray beam. A small metal sphere (target simulator) is positioned by use of the BRW phantom base and the coordinates required to treat the patient. The target simulator is then transferred to the floor stand. The floor stand drive system is set to the same coordinates and eight radiographic exposures are made at rotator angular increments of 45 degrees. If the image of the metal sphere is in the center of the beam for each of the exposures, alignment of the target center and the apex point is assured. This procedure is carried out before each treatment session.

F. Safety

All stereotactic treatment systems employing linear accelerators except the Emory X-ray Knife require that the gantry and treatment table move during therapy. The weight of a typical gantry is a few tons and the possibility of a collision between the gantry and floor stand and/or patient exists in case of a mechanical or electrical failure or through operator error. This danger does not exist when the Emory X-ray Knife is used since the gantry and treatment table are not moved during treatment. An additional hazard exists for other treatment systems since the patient's head is secured to the stereotactic ring, which is attached to the floor stand, and which in turn is bolted to the floor. The patient's body rests on the treatment table. If the table motion drive is activated by operator error or electrical failure, injury to the patient will result.

Complications

Risks of any type of stereotactic radiosurgery include the hazards of ionizing radiation, potential inaccuracy of delivering the radiation, and inappropriate use as a treatment modality when another or no treatment would be more suitable. There is very little literature dealing with the long-term risks of stereotactic radiosurgery. There are, however, well-documented cases of radiation necrosis resulting from this treatment, although the precise incidence of this complication varies in different reports.

When not being used for stereotactic radiosurgery, the unit can be used for standard radiation therapy. . . . The expense of modifying a linear accelerator for radiosurgery is a fraction of that required to purchase and run a cyclotron or Leksell gamma knife.

Martin et al.[9] performed a mail survey in which 3300 letters were sent to neurosurgeons asking them to report any AVM patients treated with radiosurgery by proton or helium ion beams. One hundred twenty responding neurosurgeons described 330 patients, of which 26 (7%) hemorrhaged after treatment, 5 fatally. New neurologic deficits were seen in 20 (6%) cases, 9 of which were severe. In 10 cases, radiation necrosis was implicated. It was concluded from this study that radiosurgery does not confer complete protection from delayed hemorrhage and may be associated with a moderate complication rate.[9]

Steiner reported four new neurologic deficits in four of 135 AVM patients (3%) treated with a gamma unit.[10] He subsequently reported seven cases of delayed radionecrosis in 300 (2%) AVM patients.[11] Kjellberg described four neurologic complications in his first 27 AVM patients treated with protons (15%), 8 in the first 74 patients treated (11%), and 9 in the first 444 (2%), with improvements in complication rates attributed to changes in doses and field sizes.[3, 12, 13] Early on, Fabrikant saw no neurologic complications in the first 55 AVM patients treated with helium ions but subsequently reported 5 neurologic deteriorations in 66 (8%) patients.[4, 14]

Betti et al.[5] described two cases of radiation necrosis out of 66 (3%) patients treated with a stereotactic linear accelerator. In retrospect, one of the patients had received external radiotherapy prior to radiosurgical treatment. Colombo et al. treated 97 AVM patients with linear accelerator radiosurgery and described three (3%) patients who complained of transient neurologic deterioration.[6]

It appears that adverse effects of radiosurgery occur in 3% to 4% of patients in the best of hands. There does not appear to be a distinct advantage of one source of radiation (gamma rays, x-rays, heavy ions) over another.

It has been previously emphasized that the technique must be extremely accurate regardless of the method one uses. Any inaccuracy in localizing the lesion or delivering the radiation may result in serious complications.

With proliferation of radiosurgical units throughout the U.S., many in the field are concerned that stereotactic radiosurgery may be utilized inappropriately. It must be emphasized that a role for radiosurgery has only been established in highly selected AVMs and certain benign brain tumors. Its precise role in these situations remains unclear. The use of stereotactic radiosurgery for other conditions such as malignant primary brain tumors or metastatic tumors is purely investigational. The actual number of patients who are ideal candidates for stereotactic radiosurgery appears to be small.

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Ruptured Gastric Artery Aneurysm Complicating Pneumococcal Sepsis: A Case Report and Review

Mark J. Costantino, M.D.

Pneumococcus is not generally recognized as a cause of mycotic aneurysms unless the patient has pneumococcal endocarditis with septic emboli.

Case Report

An 82-year-old woman was admitted to the hospital because of fever, confusion, and otitis media. A spinal fluid culture grew *Pneumococcus pneumoniae*. She was started on I.V. penicillin. Within 24 hours she became afebrile, and her mental confusion cleared.

The following day, the patient experienced abdominal pain and hypotension. A diagnosis of possible mesenteric embolus was considered, and she was transferred to Athens Regional Medical Center. On arrival, her blood pressure was 100 systolic, with a pulse of 120 on Dopamine. Her abdomen was diffusely tender, distended, and silent. Her mental state was confused. The hematocrit measured 33%; the WBC was 22,000.

An exploratory laparotomy was performed, and 1000cc of free intraperitoneal blood was encountered. Exploration revealed a hematoma in the lesser sac. The spleen was intact. The lesser sac was explored both through the gastrocolic ligament and by opening the lesser omentum. The bleeding site was found to be a ruptured aneurysm of the left gastric artery. The artery was ligated, and the aneurysm excised. The aneurysm appeared to be sacular in configuration and 2cm in diameter containing fresh thrombus.

The pathologic findings were consistent with an atherosclerotic aneurysm, and there was no evidence of arteritis, medial necrosis, or dysplasia. The patient made an uneventful recovery from surgery and has continued to do well 6 months following discharge.

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Discussion

Visceral artery aneurysms involving the splanchnic circulation are relatively rare, although 2000 have been reported in the medical literature.[1] These unusual aneurysms are important because 22% of patients reported presented as emergencies and 8.5% succumbed to rupture.[2,3] Aneurysms may develop in any of the visceral arteries but are most common in the splenic artery (60%), the hepatic artery (20%), and the superior mesenteric artery (10%). Other arteries, including the inferior mesenteric artery and the gastric or gastroepiploic arteries, are involved much less frequently.[4,5]

The pathogenesis of visceral artery aneurysms is varied and includes atherosclerosis, fibromuscular dysplasia, cyctic medial

necrosis, mycototic infections, trauma, and periarterial inflammatory processes.[1] The incidence of the various etiologies of these aneurysms varies with the location of the aneurysm. Atherosclerosis and fibromuscular dysplasia tend to be the more common causes of splenic artery aneurysms. Many splanchnic artery aneurysms, particularly those involving the superior mesenteric artery and the hepatic arteries, are mycotic in origin and thought to be caused by hematologic seeding or septic emboli from bacterial endocarditis.[6, 7] Mycotic aneurysms are generally caused by staphylococcus, salmonella, streptococcus, or a variety of gram negative bacteria. Pneumococcus is not commonly recognized as a cause of mycotic aneurysms unless the patient has pneumococcal endocarditis.

Splenic artery aneurysms are the most common and account for 60% of reported cases. These aneurysms have been reported in as many as 78% of arteriograms reviewed and in 10% of one autopsy series of elderly patients.[1, 8, 9] These aneurysms may be caused by fibromuscular dysplasia, atherosclerosis, or periarterial inflammation such as pancreatitis.[10] There is a 4:1 female-to male-predominance. These aneurysms are usually asymptomatic, although in one series 17-20% of the patients had symptoms. Rupture of the aneurysm is the presenting symptom in 3-9% of patients.[9] Rupture of splenic aneurysms is particularly associated with pregnancy. A second peak incidence of splenic seems to be in the elderly when they tend to be noted as an incidental finding by angiography or as a calcified rim seen on plain radiographs. Treatment is ligation with or without splenectomy in all symptomatic patients and women of childbearing age.

Hepatic artery aneurysms are the second most common visceral artery aneurysms and account for 20% of the total. These aneurysms are more common in males with a 2:1 ratio and tend to occur in older individuals with most patients in their sixties.[8] The etiology is varied: 32% are atherosclerotic, 24% are dysplastic, 10% are mycotic, and 20% are pseudoaneurysms caused primarily by trauma or inflammation. These patients can present with a variety of symptoms including hemorrhage into the peritoneal cavity or biliary tract, obstruction of the biliary tract, or as an incidental finding on angiography. Surgical management includes simple ligation of the aneurysm but may also require complex reconstruction of the hepatic artery and biliary tree.

Aneurysms involving the other visceral arteries are less frequent and include the superior mesenteric artery (8-10%), the celiac artery (4%), and rarely the inferior mesenteric artery.[11, 12] The etiology of these infrequent visceral aneurysms is varied, and treatment is generally ligation, although the superior mesenteric artery may require reconstruction, depending on the location of the aneurysm.

Gastric or gastroepiploic artery aneurysms account for 4% of visceral artery aneurysms. Gastric artery aneurysms are generally diagnosed at surgery and occasionally by angiography. Diagnosis has been described using ultrasound or CT scanning.[13] Seventy percent of these patients present with gastrointestinal (GI) bleeding, with the aneurysm rupturing intramurally into the GI tract. Bleeding may be acute and massive or chronic and present as an anemia. Thirty percent of these patients present with rupture into the peritoneal cavity.[14-16] Treatment is generally ligation with excision of the aneurysm if possible. Exposure can be through the lesser sac or though the lesser omentum. Asymptomatic aneurysms have been treated by percutaneous transcatheter embolization.[17] The pathologic findings are usually consistent with atherosclerosis, although medial generation is suspected in many.

Pathologic examination of the gastric artery aneurysm in our patient revealed typical atherosclerosis without evidence of arteritis or medial degeneration. Our patient had sepsis and documented pneumococcal meningitis. This organism is not generally recognized as a cause of mycotic aneurysms unless the patient has pneumococcal endocarditis with septic emboli.[6, 7] Our patient had no evidence of endocarditis. It is unlikely that she coincidentally ruptured an atherosclerotic aneurysm of the left gastric artery while recovering from pneumococcal meningitis.

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Clinical Aspects of Lumbar Intervertebral Disc Disease

George T. Tindall, M.D., Javier Garcia-Bengochea, M.D.

Introduction

THERE HAVE BEEN several developments and innovations in neuroimaging techniques and therapeutic procedures for patients with lumbar disc disease in recent years that have had a significant impact on the diagnosis and therapy of this disabling condition. These advancements include water-soluble myelography, CT/myelography, magnetic resonance imaging (MRI), microdiscectomy, and percutaneous discectomy. Additionally, there have been changes in attitudes toward certain procedures (e.g., the use of chymopapain, discography) that merit discussion. The following review of the current diagnostic and therapeutic modalities related to lumbar disc disease highlight these developments and should aid the practicing physician in the management of these patients.

There are over 200,000 operations performed annually for lumbar disc disease, and this number represents only a fraction of the number of patients with symptomatic lumbar disc disease. Surgery for a ruptured lumbar disc represents the most common operation performed by the majority of neurosurgeons.

The criteria for operation provide a basis for careful selection of patients who stand to benefit from lumbar disc surgery. The mere presence of a herniated disc is not an indication for its removal.

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Anatomy and Pathology

The fibrocartilaginous intervertebral disc forms the articulation between the bodies of the vertebrae. It provides a strong union necessary for effective action and protective alignment of the spine. Each disc consists of the nucleus pulposus and the annulus fibrosus (Figure 1). The nucleus pulposus occupies an eccentric position within the annulus, usually being closer to the posterior margin of the disc. Histologically, the disc is composed of loose, delicate, fibrous strands embedded in a gelatinous matrix that is approximately 85% to 90% water. The fibrous network is highly cellular with predominantly fusiform cells resembling reticulocytes. There are also vacuolar and nucleated chondrocytes interspersed within the matrix. A thin chondral plate is situated above and below each disc and serves to separate the vascular trabeculae of the vertebral body from the avascular disc. The annulus fibrosus is a concentric series of fibrous lamellae which en-

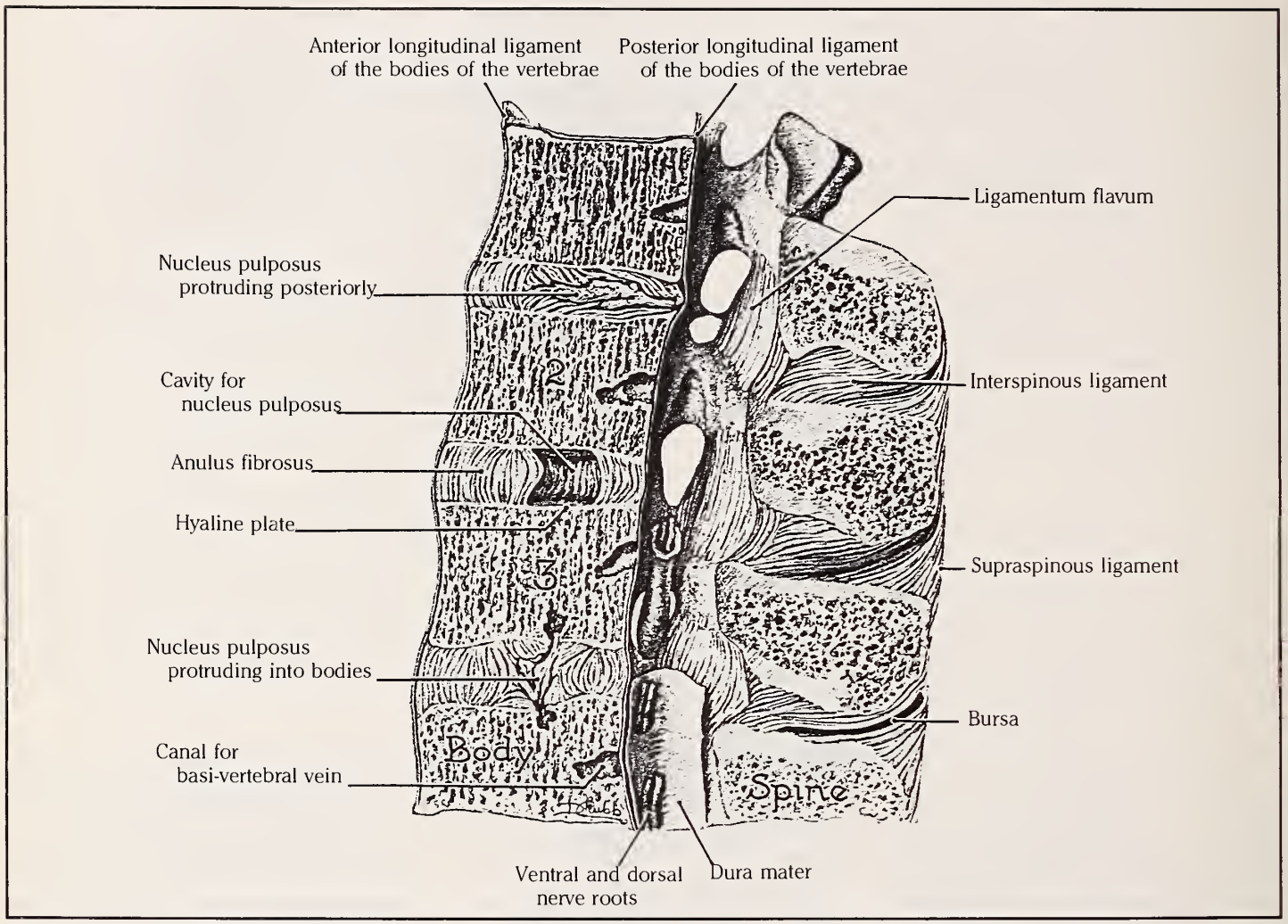


Figure 1. Sagittal section through lumbar spine illustrating anatomy of intervertebral disc.

case the nucleus and unite the vertebral bodies. The fibers cross the interspace obliquely and are thinner and fewer in number posteriorly. The nucleus and the annulus blend imperceptibly without a definite structural interface. A major function of the annulus is to withstand tension from axial loading, torsion, flexion, and extension of the spine.

Prior to herniation of a disc, both the nucleus pulposus and annulus undergo well-defined degenerative changes. Radiating cracks in the annulus develop and weaken the resistance to nuclear herniation. Rarely, there is a sudden, massive nuclear extrusion of a large volume of disc material producing a profound neurologic deficit. More commonly, the extrusion is a gradual, intermittent process. The spectrum of symptomatic disc pathology extends from simple bulging of the annulus to an actual protrusion of degenerative disc material (i.e., "free fragment") through a tear in the annulus.

Clinical Presentation

The clinical history related by patients is usually of recurrent attacks of low back pain commonly associated with physical exertion. Back pain as a result of lumbar disc disease is likely due to bulging of the annulus fibrosus with associated stretching and irritation of the sinuvertebral nerve in the posterior longitudinal ligament. The sinuvertebral nerve originates from the dorsal ramus of the spinal nerve and courses back through the intervertebral foramen to innervate the articular connective tissue, periosteum, meninges, posterior longitudinal ligament, and vascular structures associated with the vertebral canal. However, the nucleus pulposus and the inner laminae of the annulus fibrosus lack innervation. Further herniation and/or bulging of the degenerated disc results in compression of a peripheral nerve root producing pain radiating into the leg (sciatica), typically into the posterolateral aspects of the thigh and calf. The back and leg pain associated with disc rupture is almost invariably exac-

Table 1. Neurologic Impairment Due to Herniated Lumbar Disc

Site of Disc Herniation	*Nerve Root Involvement*	*Expected Neurologic Findings*
L3-4	L4	Weakness and/or mild atrophy of quadriceps femoris. Knee jerk absent or impaired. Loss or impaired sensation, medial aspect of leg. Intact ankle jerk.
L4-5	L5	Weakness of dorsiflexion of foot. Mild atrophy of anterior tibialis and extensor hallucis longus. Loss or impaired sensation, medial foot, great toe. Intact ankle jerk.
L5-S1	S1	Weakness plantar-flexion of foot (relatively uncommon). Loss or impairment of ankle jerk. Loss or impaired sensation, lateral foot, digits 4 and 5.

erbated by physical activity such as bending, lifting, or straining and is alleviated by rest, particularly recumbency.

Examination

The neurologic examination is important in formulating and confirming a diagnosis of lumbar disc disease. Approximately 95% of lumbar disc herniations are located at either the L4-L5 or the L5-S1 interspace. Typically, a herniated disc at the L4-L5 interspace compresses the L5 nerve root and a disc at L5-S1 involves the S1 root. Since each nerve root has a characteristic sensorimotor distribution, compromise of either the L5 or S1 root by disc compression produces typical neurologic findings. The neurologic involvement that may be seen with disc herniations at different levels is shown in Table 1. These anatomic relationships enable the physician to determine the site of disc rupture.

In addition to localizing the involved interspace of disc herniations, the examination establishes a baseline for subsequent assessments and enables the physician to decide on the most appropriate therapy. For example, a typical history with moderate to marked weakness of dorsiflexion of the foot and an appropriate neuroradiologic correlate suggesting disc rupture is usually an indication for operation rather than for a more conservative, nonoperative course of therapy.

Mechanical signs, findings dependent upon stretching or movement of the involved nerve root against the herniated disc, are valuable in establishing a diagnosis and in deciding upon the appropriate therapy. Methods to elicit mechanical findings include the straight-leg raising test; popliteal compression, well-leg raising test; and to a lesser extent, the degree of forward bending of the lumbosacral spine and sciatic tenderness. The straight-leg raising test, the most common mechanical finding associated with symptomatic lumbar disc herniation, is performed with the patient in the supine position by passively raising the extended leg on the symptomatic side. The examiner notes and records the angle of the straight leg to the horizontal plane when the patient registers pain, which is a positive response. Tension of the compressed nerve root and irritation of the dura mater are thought to be responsible for the leg and back pain, respectively.

Although chemonucleolysis may benefit patients with small disc bulges, the lower cure rate and higher morbidity make it a less desirable therapeutic option.

Neurodiagnostic Tests

Recent advances in neuroimaging have improved characterization of lumbar disc disease relative to the neural, bony, and soft tissue elements. Computerized tomography (CT) with or without preceding myelography has been the standard diagnostic study in the evaluation of symptomatic lumbar disc disease and has eliminated the need for studies such as epidural venography and discography. The advent of magnetic resonance imaging (MRI) has complemented CT/myelography, and in numerous centers MRI is applied as the initial diagnostic procedure in the routine evaluation of symptomatic lumbar disc disease. Adjunctive studies including lumbosacral spine films and electromyography may provide useful information in complicated cases but are routinely unnecessary.

Computerized Tomography

Introduced in 1973, CT has evolved to provide clear visualization of the intervertebral disc in relation to the bony structures and the dimensions of the spinal canal. In a review of 461 patients with radiating leg pain suspected of having a disc rupture, Schipper et al. found CT more specific (77% vs 67%) than myelography in correctly identifying a herniated disc.[1] Facet degeneration and hypertrophy as well as marginal sclerosis are best seen using CT. Vertebral and para-

vertebral neoplasms and hypertrophy of ligamentous structures are also readily demonstrated with CT scanning.

The major limitations of CT are the inability to reliably delineate the dural sac and neural tissue and the lack of visualization of the conus medullaris and upper lumbar segments on routine scanning. Image artifact prevents adequate resolution of the soft tissues in obese patients, precluding the use of CT without intradural contrast. Additionally, a large herniated nucleus pulposus occupying the majority of the spinal canal may be missed with plain CT.

The use of intravenous gadolinium (DPTA)-enhanced MRI appears to be more effective than CT with intravenous contrast or myelography/CT in the evaluation of recurrent disc herniation versus epidural fibrosis (scarring) in previously operated patients.

Myelography

Although supplanted by CT as the initial diagnostic procedure, myelography remains valuable in diagnosing and localizing a herniated nucleus pulposus. In the 1970s, the introduction of the water-soluble agent metrizamide (Amipaque, Winthrop Labs) led to safer myelography with toxicity limited to nausea, vomiting, rare seizures, and occasionally, aseptic meningitis. Recently, the development of less toxic, nonionic substances — iohexol (Omnipaque, Winthrop Labs) and iopamidol (Isovue, Squibb) — has afforded comparable contrast resolution to metrizamide and has gained widespread usage, although these agents are more expensive than metrizamide.

Myelography remains useful in the evaluation of the patient with an equivocal plain CT scan for unilateral or central herniated nucleus pulposus, a polyradiculopathy, recurrent or persistent symptoms after previous surgery, or severe scoliosis that distorts standard anatomic relationships as depicted on axial CT scans. The accuracy in detecting herniation is higher (80% to 90%) at the L4-L5 interspace than at L5-S1 due to the variability of the anterior epidural space at the latter level.[1] The typical appearance of a herniated disc on myelography is shown in Figure 2.

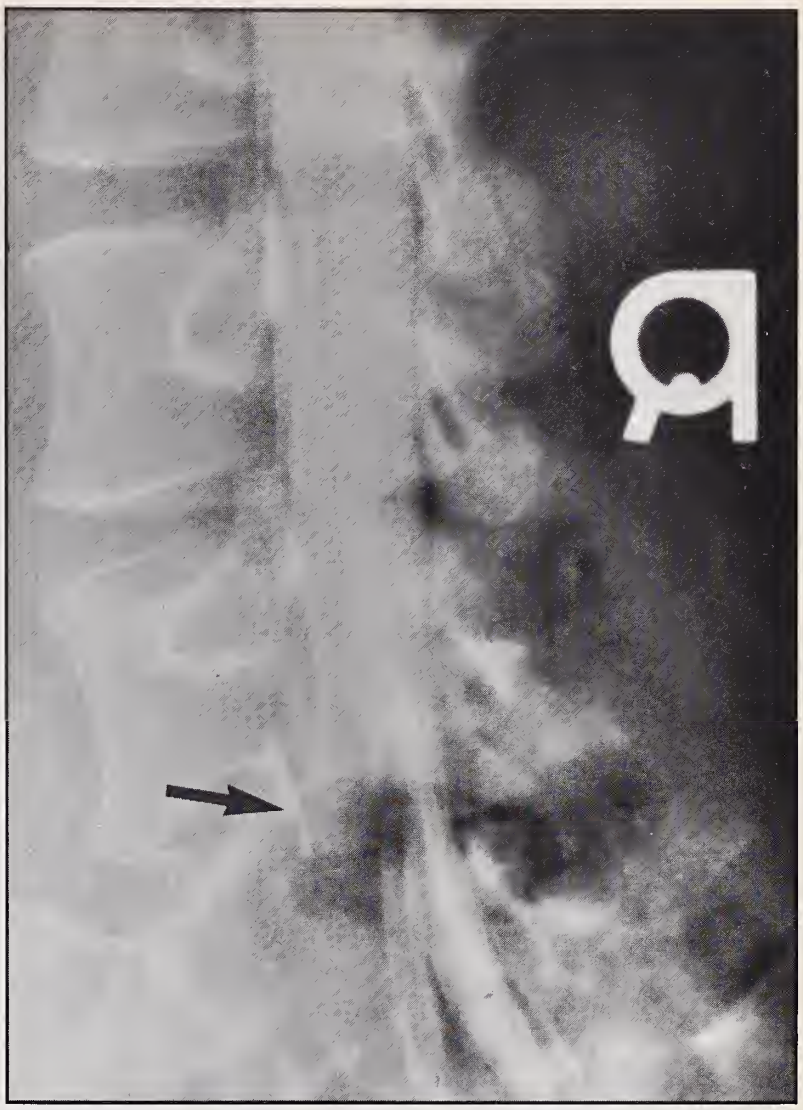
Myelography followed by CT has been the standard procedure in the diagnosis of lumbar disc disease during the last decade. Contrast enhancement of the dural sac and visualization in the axial plane relative to the soft tissue and bony structures more accurately identifies neural impingement by herniated lumbar discs or osteophytes than myelography or CT alone (Figure 2), or in the case of osteophytes alone, by MRI. The ease of administration and safety of iopamidol and iohexol has permitted myelography/CT scanning to be performed on an outpatient basis in many institutions. Myelography continues as the neurodiagnostic study of choice for arachnoiditis and leptomeningeal spread of tumor.

Magnetic Resonance Imaging

The efficacy of magnetic resonance imaging in the evaluation of lumbar disc disease has been studied since its routine use began in the mid-1980s. There has been improved resolution of soft tissue over CT due to superior contrast resolution. These techniques include the use of the surface coil, multi-slice spin-echo, cardiac gating, and gradient echo pulse sequences, which increase CSF signal with relatively short acquisition times and essentially produce myelogram-like images.[2]

Back pain as a result of lumbar disc disease is likely due to bulging of the annulus fibrosus with associated stretching and irritation of the sinuvertebral nerve in the posterior longitudinal ligament.

One advantage of MRI is the protection to the patient from ionizing radiation or from an invasive procedure such as lumbar puncture. Additionally, multiplanar imaging, including sagittal views, demonstrate upper lumbar disc pathology, vertebral body neoplasms, conus medullaris lesions, intraspinal meningiomas, and neurofibromas that are not viewed on routine CT scanning or that are not always appreciated with myelography. Herniated lumbar discs are usually perceived as extradural defects of low-to-intermediate signal on T1-weighted images relative to the intervertebral disc material (Figure 3). On T2-weighted sequences, they are of high signal intensity and when separate from the adjacent interspace are representative of a sequestered disc. Axial images made through clinically or radiographically suspicious interspaces, using both T1 and T2 imaging techniques, are important in viewing nerve root displacement, disc lateralization, dural sac impingement, facet enlargement, and hypertrophy of the ligamentum flavum.



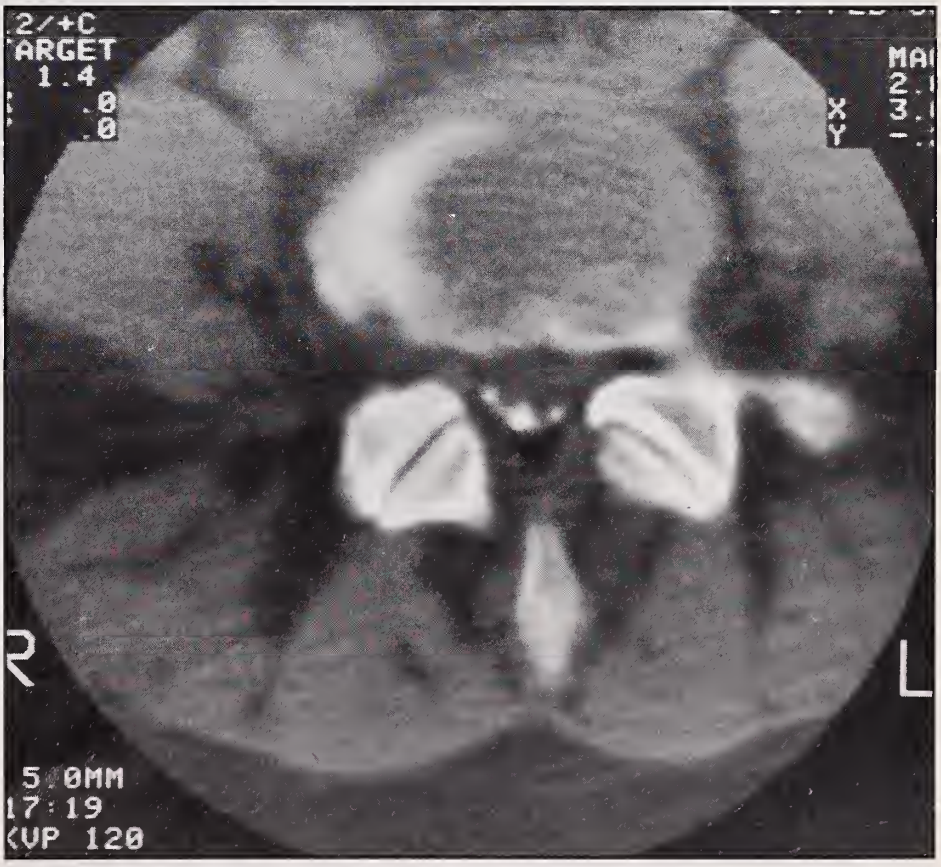


Figure 2. (Top) Lumbar myelogram oblique view demonstrating extradural defect with nerve root cut-off herniated nucleus pulposus at L4-L5 on the left. (Bottom) CT scan following myelogram in the same patient showing compression of the dural sac on the left by the herniated disc.

The increasing availability and concerns regarding cost-effectiveness of MRI question its efficacy as a reliable diagnostic study compared to CT/myelography. In a comparison of surface coil MRI, CT with or without myelography and myelography alone in 48 patients with surgically confirmed lumbar disc disease, Modic et al. reported that MRI and CT/myelography each had approximately 83% agreement with the surgical findings regarding the type of pathology (e.g., disc degeneration, vertebral canal stenosis, or frank disc herniation) and the location, while myelography was in agreement in 72% of cases. He concluded that a technically adequate MRI was equivalent to CT/myelography in the diagnosis of lumbar disc disease.[3] In cases where there is no clear radiographic evidence of disc herniation, annular tears may be viewed on T2-weighted images or on T1-weighted gadolinium (DTPA)-enhanced images due to the presence of vascularized granulation tissue in the tear.[4]

The use of intravenous gadolinium (DTPA)-enhanced MRI appears to be more effective than CT with intravenous contrast or myelography/CT in the evaluation of recurrent disc herniation versus epidural fibrosis (scarring) in previously operated patients[5] (Figure 4). Relative to the typical MRI characteristics of extruded disc material, fibrosis appears as abnormal epidural soft tissue enhancement with a wide-based linear or crescent configuration on early, axial T1-weighted images. Conversely, herniated disc material rarely enhances with gadolinium. Poor resolution of bone makes MRI less desirable than CT in evaluating elderly patients with facet hypertrophy or spondylosis secondary to disc degeneration. Contraindications to obtaining an MRI are implanted metallic objects, such as cardiac pacemakers and cerebral aneurysm clips.

Lumbrosacral spine films alone may aid in the evaluation of patients with back and/or leg pain. Standard anteroposterior (AP), lateral, and oblique views are helpful

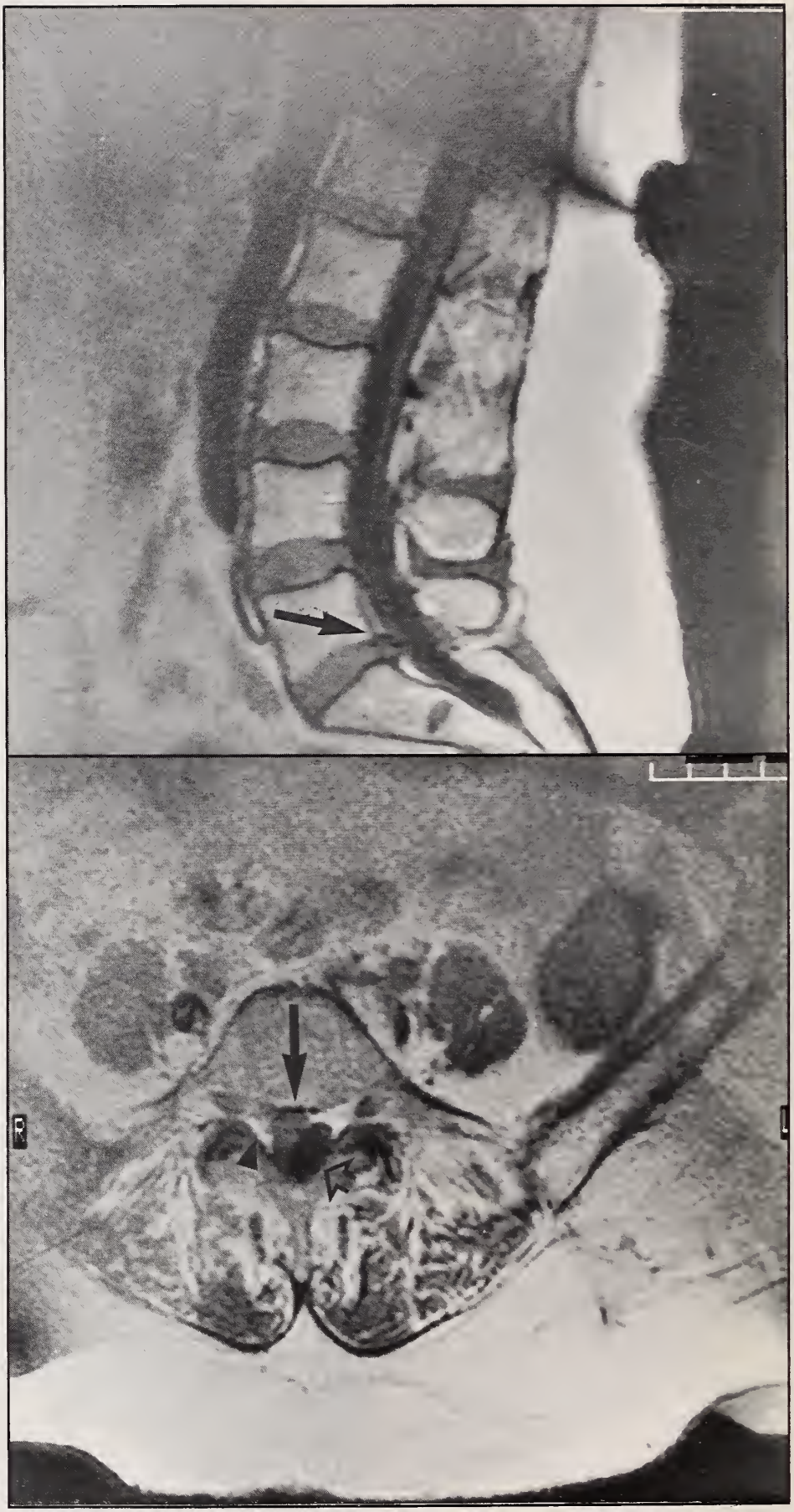


Figure 3. (Top) Sagittal T1-weighted MRI demonstrating a disc herniation at L5-S1 on the right (arrow). (Bottom) The corresponding axial section shows displacement of the epidural fat (arrowhead) and dural sac (open arrow) by the herniated disc on the right (arrow).

in identifying spondylolisthesis, pars interarticularis defects, compression fractures, neoplasms, and degenerated intervertebral spaces. However, conventional x-rays are not adequate to evaluate the disc and other soft tissue structures and add little information above that gained from a CT scan and/or an MRI.

Electromyography

Electromyography (EMG) usually supports the clinical and radiographic findings in the patient with lumbar disc disease by identifying the involved nerve root. EMG is reserved for the evaluation of patients with atypical low back and leg pain or equivocal radiographic studies. Rarely does a positive EMG influence the decision involving surgical management of a patient and, therefore, is not recommended in the routine investigation of a patient with suspected or proven herniated lumbar disc.

Differential Diagnoses

While numerous pathologic entities may cause back and leg pain, the most common lesions include herniated nucleus pulposus, osteoarthritis, lumbar spondylosis, spondylolisthesis, and neoplasm. Neoplasms may be metastatic, primary of bony origin, or intradural spinal tumors of neural origin. In adults between the ages of 25 and 45 years, herniated nucleus pulposus is the most common cause of back and leg pain

Certain aspects of the patient's history are helpful in differentiating other pathologic conditions from a herniated disc. The occurrence of nocturnal pain, particularly after the patient has been recumbent more than an hour, suggests spinal cord tumor. Pain on arising in the morning, which improves with resumption of normal activity and is exacerbated with rigorous activity, implies osteoarthritis and/or lumbar spondylosis.

When chronic recurrent back pain begins in the late teens, especially pain that worsens with activity, this raises the possibility of spondylolisthesis, a condition that

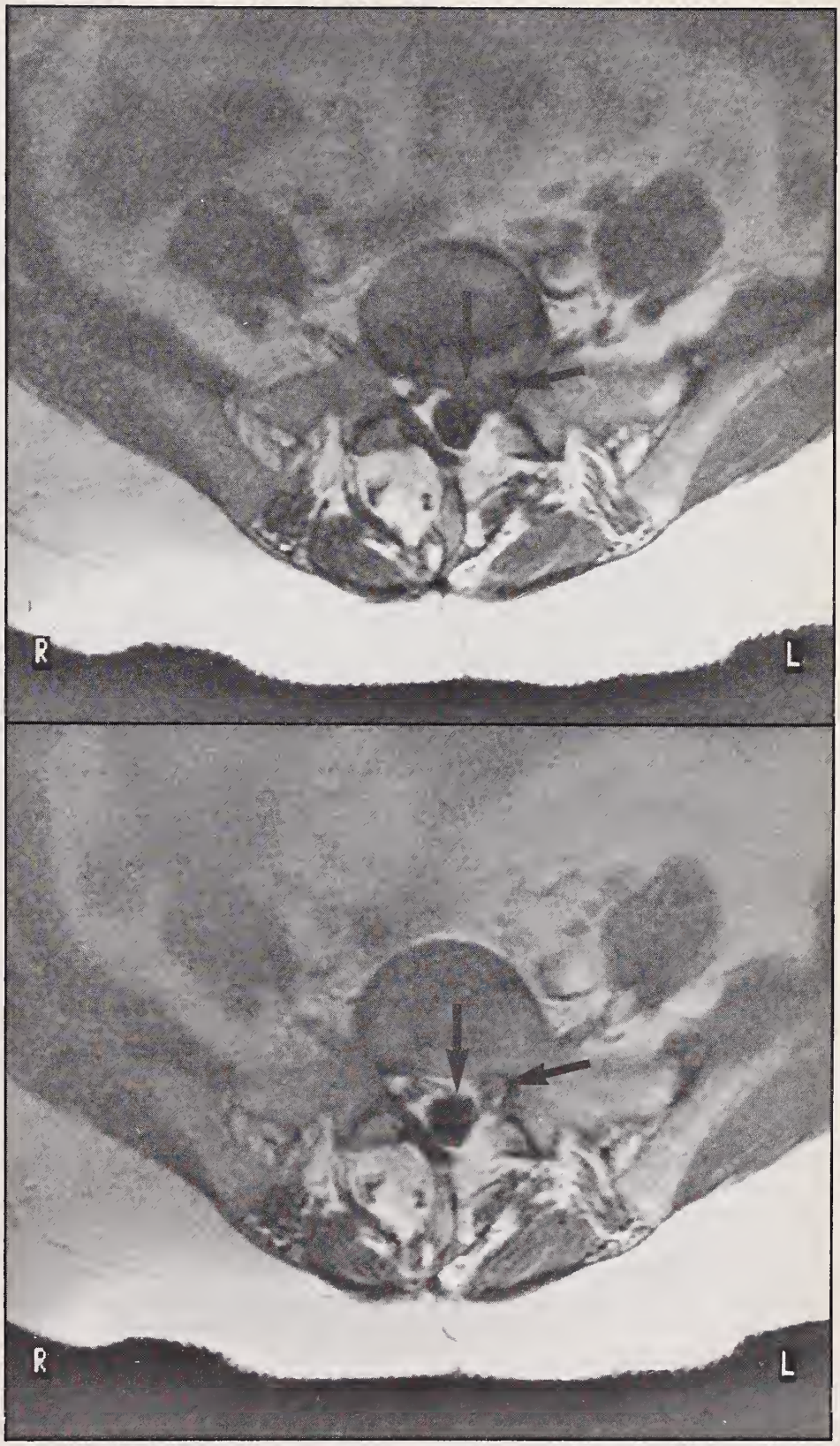


Figure 4. (Top) T1-weighted MRI through L5-S1 in a previously operated patient with recurrent symptoms. It is unclear whether the isodense area (arrow) adjacent to the dural sac is scar or recurrent disc. (Bottom) Intravenous administration of gadolinium-GPTA demonstrates enhancement of the area indicating scar tissue. Note the normal contour of the dural sac and the nondisplaced nerve root (arrow).

can be diagnosed by the appropriate lumbosacral films. Metastatic lesions tend to occur in patients between the ages of 45 and 70 years and are manifested as localized back pain that is tender to percussion. The pain is usually gradual in onset over several days to weeks, but may be acute in the advent of a pathologic fracture or collapse of a vertebra. Radicular signs and symptoms may be absent. Most metastatic lesions are seen as lytic lesions on plain films and destructive lesions on CT scan. The epidural, extravertebral metastatic tumor typically involves the anterior epidural space and is distinguished from herniated or bulging disc material by its irregular appearance extending laterally and vertically beyond the interspace. Neurofibromas or schwannomas are suspected in patients with the stigmata of von Recklinghausen's disease, and these lesions are readily seen with gadolinium-enhanced MRI or myelography.

Treatment

The choice of conservative or operative therapy is determined by the duration and severity of symptoms and the presence of neurologic deficits. The indications for surgery are straightforward and include the presence of a disabling and/or potentially progressive neurologic deficit and intractable pain that fails to respond to a conservative approach after an appropriate interval of time (10 to 14 days). Neurologic deficits include the development of segmental motor loss (e.g., a significant foot drop) or paraparesis, and loss of sphincter (e.g., bowel and/or bladder) function. Unless pain has become intractable or a disabling or potentially progressive neurologic deficit is present, a conservative approach is advised. The criteria for operation provide a basis for careful selection of patients who stand to benefit from lumbar disc surgery. The mere presence of a herniated disc is not an indication for its removal.

Conservative treatment consists of bed rest on a relatively firm, nonsagging mattress; the use of a lumbosacral corset; an exercise program (e.g., Williams' exercises); and the curtailment of strenuous physical activity. The period of bed rest is usually from 7 to 14 days, and the patient should be allowed up only for meals and bathroom privileges. A corset should be worn whenever the patient is ambulatory and as long as pain is a problem.

The following review of the current diagnostic and therapeutic modalities related to lumbar disc disease highlight the developments in neuroimaging techniques and therapeutic procedures and should aid the practicing physician in the management of these patients.

When surgery is indicated, a noncontrast CT scan or, if cost and/or availability are not problematic, an unenhanced MRI of the lumbar spine is obtained. A positive study that correlates clinically with a radicular syndrome is sufficient to proceed with operation. In either case, an equivocal result, or in the former case a polyradiculopathy, especially a cauda equina syndrome, warrants myelography followed by CT scanning. In the postoperative patient with recurrent signs and symptoms of radiculopathy, a gadolinium (DPTA)-enhanced MRI is the optimal initial diagnostic procedure to determine the presence of recurrent disc versus scar.

Surgery is performed using either spinal or preferably general anesthesia. Younger and middle-aged patients without evidence of severe degenerative disc disease should be positioned on the operating table in a prone position on a special operating table/frame (such as the Andrews frame) with the lower extremities flexed to 90 degrees at the hips and knees. A 3 to 4 inch midline lumbar incision is made over the appropriate interspace. The muscles and soft tissues are dissected subperiosteally off the spinous processes and laminal arches of the vertebra. After identifying the correct interspace (either by inspection and palpation or with intraoperative x-ray), a small rim of bone is removed from the lamina superiorly and inferiorly, and the ligamentum flavum is excised on the side of the disc herniation. The nerve root, which is usually taut from the underlying disc, is retracted medially. The ruptured disc fragment is removed with a pituitary rongeur (Figure 5). Degenerated disc fragments are then removed from within the interspace. In an effort to prevent scarring, a piece of subcutaneous fat is placed over the laminotomy site and exposed nerve root. The incision is then closed in anatomic layers. Postoperatively, the patient is ambulated the following day and is discharged from the hospital in 4 to 5 days.

Results of Treatment

The results of conservative treatment reported by Armstrong demonstrate the efficacy of nonoperative therapy in many cases.[6] Although less than 20% of the patients achieved complete relief of symptoms, approximately 60% obtained partial relief, which was sufficient to return to normal activity and work with some limitations. Ten to 20% achieved no significant re-

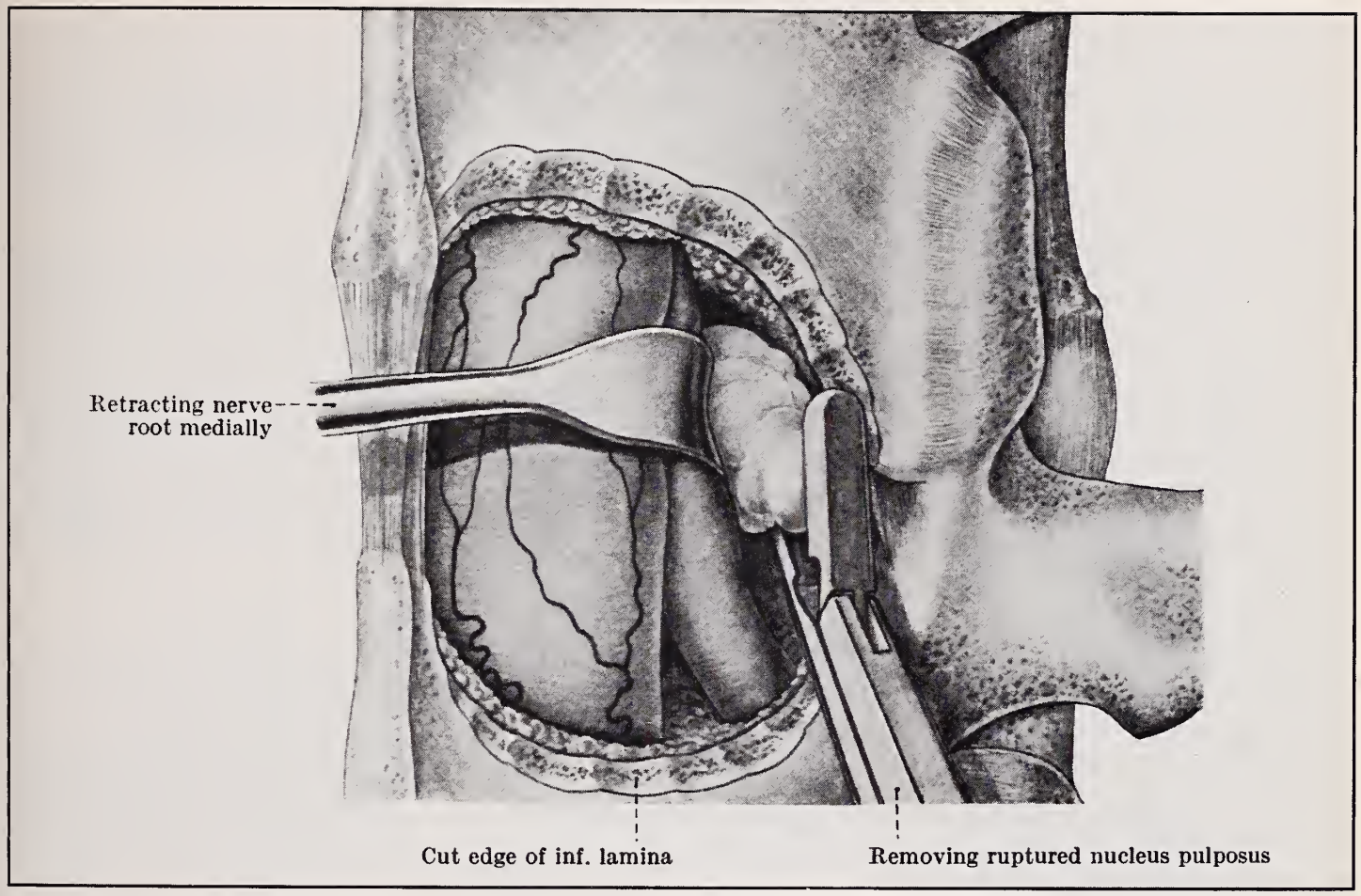


Figure 5. Intraoperative illustration of a discectomy with decompression of the nerve root.

lief and ultimately had surgery.

The results of surgery are excellent and, in properly selected patients in whom strict criteria have been followed, relief of pain is expected in at least 85% of cases. Shannon and Paul analyzed the results of surgery in 323 patients with lumbar disc disease.[7] Firm criteria for diagnosis and surgery were followed, and compensation cases were not included. There were 241 men and 82 women. Following surgery, 89% of the men and 79% of the women became asymptomatic and had no mechanical signs referable to the nerve root in question. Symptomatic recurrent disc disease developed in 4.6% of these patients.

Spinal fusions are not regularly indicated in the routine excision of a herniated lumbar disc. The predominant indications for fusion are patients with associated spondylolisthesis or young patients who demonstrate radiographic instability and persistent back pain following extensive unilateral or bilateral laminectomy.

In recent years, microdiscectomy has become increasingly popular. Proponents of this technique recognize smaller incisions, better illumination, improved visualization of the affected nerve root, reduced laminotomy, and epidural hemostasis as advantages over conventional discectomy.[8] Comparable results to standard open discectomy were reported by Wilson and Harbaugh[9] with 2 to 3 days shorter hospitalization for patients receiving microdiscectomy. Attempts at microdiscectomy, however, have resulted in missed disc fragments concealed medially anterior to the dura, behind the vertebral body, or laterally in the foramen that are due to inadequate exposure. The indications for microdiscectomy are essentially the same as those for conventional discectomy; however, the application of microdiscectomy should be judicious for large disc herniations or suspected free fragments based on the myelogram/CT or MRI. Otherwise, the choice of open or microdiscectomy is mandated by the surgeon's personal

preference and familiarity with either technique.

Chemonucleolysis was introduced in 1963 as an alternative, less invasive therapy for symptomatic lumbar disc disease. Despite conflicting results of retrospective reviews and prospective trials regarding the efficacy of chemonucleolysis, the procedure regained popularity in the late 1970s and early 1980s. Randomized prospective trials since that time indicate that chemonucleolysis has a significantly lower success rate than conventional discectomy, a higher recurrence rate, and results in a higher incidence of disc space infections. A recent multicenter randomized clinical trial of open discectomy versus chemonucleolysis reported by van Alphen et al.[10] demonstrated the superiority of open surgical therapy and emphasized the markedly reduced success rates of surgery on patients in whom chemonucleolysis was ineffective and required operation. In a retrospective analysis of 126 cases of microdiscectomy and chemonucleolysis, Zeigler[11] reported that 54% of patients surveyed who underwent chemonucleolysis had persistent pain and/or paraspinous muscle spasm for 2 to 6 weeks compared to only 5% in the operative group. Additionally, anaphylaxis is an uncommon, but life-threatening complication from the administration of the chymopapain protein used in chemonucleolysis.

Although chemonucleolysis may benefit patients with small disc bulges, the lower cure rate and higher morbidity make it a less desirable therapeutic option. For these reasons, chemonucleolysis is not recommended as a therapeutic option in patients with ruptured lumbar discs.

Recently, automated percutaneous lumbar nucleotomy has been employed as an alternative to conventional surgery for the patient with nucleotomy may be offered to the patient with back pain and/or radiculopathy, who has failed conservative measures and who demonstrates on CT or MRI a disc bulge or herniation contained within the annulus fibrosus. A contraindication to the use of percutaneous discectomy would be the suspicion of a free herniated disc fragment. The initial report in one series appears encouraging, with an 86% improvement in pain or neurologic deficit after 4 months of follow-up.[12] Larger studies with longer postoperative follow-up will be required to determine the efficacy and specific role of percutaneous nucleotomy in patients with disc disease.

The major limitations of CT are the inability to reliably delineate the dural sac and neural tissue and the lack of visualization of the conus medullaris and upper lumbar segments on routine scanning.

Summary and Conclusions

The diagnosis and management of lumbar disc disease has undergone significant changes in recent years. This is especially true for diagnostic imaging studies (MRI and CT). Currently, CT/myelography or unenhanced MRI may be used to confirm the diagnosis and the level of involvement of lumbar disc disease.

The indications for lumbar disc surgery include patients with neurologic deficits and/or those in whom intractable pain does not respond to conservative measures. Conventional disc surgery and/or microdiscectomy are both good operative procedures for lumbar disc disease, and each yields excellent results when criteria for diagnosis and surgery are strictly followed.

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3. Ross JS, Modic MT, Masaryk TJ. Tears of the annulus fibrosus: assessment with Gd-DTPA-enhanced MR imaging. AJR 1990;154:159-62.
4. Modic MT, Masaryk T, Boumphrey F, et al. Lumbar herniated disk disease and canal stenosis: prospective evaluation by surface coil MR, CT, and myelography. AJR 1986;147:757-65.
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7. Shannon N, Paul EA. L-4/5 and L-5/-1 disc protrusions: analysis of 323 cases operated on over 12 years. J Neurol Neurosurg Psychiatr 1979;42:804-809.
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9. Wilson D, Harbaugh R. Microsurgical and standard removal of a protruded lumbar disc: A comparative study. Neurosurgery 1981;8:422-427.
10. van Alphen HAM, Braakman R, Bezemer PD, et al. Chemonucleolysis versus discectomy: a randomized multicenter trial. J Neurosurg 1989;70:869-875.
11. Zeigler HE Jr. Comparison of chemonucleolysis and microsurgical discectomy for the treatment of herniated lumbar disc. Spine 1987;12:796-799.
12. Diagnostic and therapeutic technology assessment. Percutaneous lumbar discectomy for herniated discs. JAMA 1989;261:105-109.

Bibliography of Laparoscopic Cholecystectomy

Editor's Comment: *The literature of surgery has been sprinkled rather liberally through the years with the writings of a great variety of individuals describing the inception, progressive development, complications related to and changing indications for the management of biliary tract disease.*

The recent development of the ability to remove the gallbladder by means of the laparoscope has generated a rather limited bibliography. It is of historic significance that the first such operation as best one can document was performed by a Georgia surgeon and first reported in this Journal *(McKernan & Saye,* JMAG *March, 1989). Your editor thought it would be of benefit to the surgical community and of casual interest to medical literature bibliophiles to examine by means of a literature search the available bibliography pertaining to the subject of laparoscopic cholecystectomy. The following represents that bibliography as compiled in July, 1990.*

Search Mode—Enter Query

1. ge (gallbladder-diseases with su)
RESULT 1980 DOCUMENTS

2. 1 or gallbladder-su or cholecystectomy
RESULT 4328 DOCUMENTS

3. 2 and peritoneoscopy
RESULT 50 DOCUMENTS

4. 2 and laparoscope 3
RESULT 46 DOCUMENTS

5. 3 or 4
RESULT 61 DOCUMENTS

6. 1/5 lg = en
RESULT 16 DOCUMENTS

BRS SEARCH MODE—ENTER QUERY

7. 5 and (ge fr).lg
SEARCHING
RESULT 4 DOCUMENTS

8. 6 or 7
RESULT 20 DOCUMENTS

9. pc bibl,lg,ab/all

1
AN 90238805. 90082.
AU Ponsky-J-L.
TI Advances in therapeutic biliary endoscopy.
SO Ohio-Med. 1990 Mar. 86(3). P 189-90.
LG EN.

2
AN 90203833. 90071.
AU McKernan-J-B. Saye-W-B.
TI Laparoscopic general surgery [see comments].
SO J-Med-Assoc-Ga. 1990 Mar. 79(3). P 157-9. (Review).
LG EN.
AB 9 Refs.

3
AN 90203831. 90071.
AU Wilson-J-P.
TI Commentary on laparoscopic cholecystectomy [editorial; comment].
SO J-Med-Assoc-Ga. 1990 Mar. 79(3). P 149
LG EN.

4
AN 90193901. 90062.
AU Perissat-J. Collet-D. Belliard-R.
TI Gallstones: laparoscopic treatment— cholecystectomy, cholecystostomy, and lithotripsy. Our own technique.
SO Surg-Endosc. 1990. 4(1). P 1-5.

LG EN.
AB The authors describe their own technique for the treatment of gallbladder stones using a laparoscopic approach. They first evacuate the stones with the aid of an intracorporal ultrasonic lithotriptor (Olympus, LTUS). Next they perform a cholecystostomy (17 cases) or a cholecystectomy (25 cases). The first 42 cases are reported, and the results have been good. Author-abstract.

5
AN 90188971. 90062.
AU Cuschieri-A.
TI The laparoscopic revolution —walk carefully before we run [editorial].
SO J-R-Coll-Surg-Edinb. 1989 Dec. 34(6). P 295.
LG EN.

6
AN 90185642. 90062.
AU Moran-E-J.
TI Surgery adds to arsenal against gallstones.
SO Hospitals. 1990 Apr 5. 64(7). P 53-4.
LG EN.

7
AN 90185036. 90062.
AU Auguste-L-J.
TI Laparoscopy-guided percutaneous cholecystostomy.
SO Gastrointest-Endosc. 1990 Jan-Feb. 36(1). P 58-60.
LG EN.

8
AN 90164863. 90052.
AU Cuschieri-A. Berci-G. McSherry-C-K.
TI Laparoscopic cholecystectomy [editorial].
SO Am-J-Surg. 1990 Mar. 159(3). P 273.
LG EN.

9
AN 90128417. 90051.
AU Cuschieri-A. Abd-el-Ghany-A-A. Holley-M-P.
TI Successful chemical cholecystectomy: a laparoscopic guided technique.
SO Gut. 1989 Dec. 30(12). P 1786-94.
LG EN.
AB A laparoscopic guided technique of percutaneous chemical destruction of the gall bladder is described. The procedure entails the creation of a percutaneous access cholecystostomy for stone removal/fragmentation. After endoscopic occlusion of the cystic duct, the alkali corrosive, sodium carbonate was instilled into the gall bladder for 10-15 minutes. The treatment was applied in 11 animals with three deaths because of technical mishaps and eight survivors, in five of which a histologically confirmed complete destruction of the gall bladder (chemical cholecystectomy) was achieved without damage to the rest of the biliary tract or liver parenchyma. Author-abstract.

10
AN 90107915. 90042.
AU Perissat-J. Collet-D-R. Belliard-R.
TI Gallstones: laparoscopic treatment, intracorporeal lithotripsy followed by cholecystostomy or cholecystectomy a personal technique.
SO Endoscopy. 1989 Dec. 21 Suppl 1. P 373)4.
LG EN
AB The authors describe a personal technique for the treatment of gallbladder stones using a laparoscopic approach. They first evacuate the stones with the aid of an intracorporeal ultrasonic lithotriptor (L.U.S. Olympus). They next perform a cholecystostomy or a cholecystectomy. The first 40 cases are reported, and good results were obtained. Author-abstract.

11
AN 90107914. 90042.
AU Frimberger-E.
TI Operative laparoscopy: cholecystotomy.
SO Endoscopy. 1989 Dec. 21 Suppl 1. P 367-72.
LG EN

12
AN 90093175. 90041.
AU Salm-R. Noldge-G. Buscher-H-P.
TI [Cholelithiasis—non-surgical intervention. Definitive and combined use].
SO Fortschr-Med. 1989 Nov 10. 107(32). P 683-7. (Review).
LG GE.
AB New endoscopic and radiological techniques, together with pharmacological developments, prompted by high-surgical risk patients or those developing bile duct stones after prior cholecystectomy—but also by the wish to have less invasive alternatives available, have led to a variety of non-operative therapeutic modalities in gallstone diseases. Both endoscopic and radiological procedures are employed to remove stones from the biliary tract and gallbladder.

Extracorporeal lithotripsy and chemical litholysis are being increasingly employed to treat gallbladder stones. Laparoscopic cholecystectomy is a new operative possibility. These different approaches, sometimes used in combination, are associated with different preconditions for success. Indications and results must be measured against the gold standard of cholecystectomy. Author-abstract. 31 Refs.

13
AN 90049671. 90021.
AU Reddick-E-J. Olsen-D-O.
TI Laparoscopic laser cholecystectomy. A comparison with mini-lap cholecystectomy.
SO Surg-Endosc. 1989. 3(3). P 131-3.
LG EN.
AB The standard treatment of cholelithiasis in the United States is surgical removal of the gallbladder, but this treatment often has a major economic impact on the patient: major surgery, lengthy hospitalization, and several weeks' absence from work. Because of this economic factor, there has been a movement toward non-invasive methods, but they, too, have their drawbacks: long-term medical therapy; a high risk of stone recurrence because the diseased gallbladder is still in place. We therefore developed a means of performing a cholecystectomy through a laparoscope using laser technology, the results of which are compared here with the results in a series of "mini-lap" cholecystectomies that we also performed during the same time period. Author-abstract.

14
AN 90049670. 90021.
AU Abd-el-Ghany-A-B. Holley-M-P. Cuschieri-A.
TI Percutaneous stone clearance of the gallbladder through an access cholecystostomy. Laparoscopic-guided technique.
SO Surg-Endosc. 1989. 3(3). P 126-30.
LG EN.
AB A laparoscopic-guided technique of percutaneous gallstone fragmentation/removal has been developed in the pig. The procedure entails the creation of a percutaneous access cholecystostomy. The access tract can be safely dilated after 7 days to F16, thereby allowing the introduction of both the Olympus flexible and the Berci-Shore rigid choledochoscopes. Following endoscopic occlusion of the cystic duct by a biliary balloon catheter, stone fragmentation can be conducted under direct visual control. In this particular study, electrohydraulic lithotripsy was performed of human cholesterol and bile-pigment stones inserted into the gallbladder of 16 pigs. The gallstone debris resulting from lithotripsy was then washed out with saline. Larger residual fragments could easily be extracted with the Dormia basket under visual guidance. There was a significant positive correlation between stone size (r = 0.98) and weight (r = 0.96) and the number of pulses needed to achieve satisfactory stone fragmentation. The gross composition of the stones (predominantly cholesterol or pigment) did not influence the number of pulses required. Electrohydraulic lithotripsy caused an explosion effect (the fragments hit the gallbladder wall), causing submucosal haematoma formation. This, however, was not followed by any untoward effect until sacrifice of the animals 10-16 weeks later. Electrohydraulic shocks delivered to the gallbladder wall itself resulted in larger haematoma formation and breach of the gallbladder mucosa with active bleeding into the gallbladder lumen, but again no instance of gallbladder perforation was encountered. (ABSTRACT TRUNCATED AT 250 WORDS). Author-abstract.

15
AN 90046496. 90021.
AU Roseau-E.
TI [Celioscopic cholecystectomy, an exceptional technic (letter)].
SO Presse-Med. 1989 Oct 7. 18(31). P 1528.
LG FR.

16
AN 90033984. 90021.
AU Martin-P. Lemaire-A.
TI [Cholecystectomy by celioscopy (letter)].
SO Gastroenterol-Clin-Biol. 1989 Aug-Sep. 13(8-9). P 751-2.
LG FR.

17
AN 89296760. 89000.
AU Dubois-F. Berthelot-G. Levard-H.
TI [Cholecystectomy by coelioscopy]
SO Presse-Med. 1989 May 13. 18(19). P 980-2.
LG FR.
AB Operative coelioscopy, widely used in gynaecological surgery and appendectomy, can be helpful in cholecystectomy. Sixty-three patients have been operated upon by this technique which has the advantages of small

scars and rapid recovery with shortening of hospital stay. At the moment, its sole indication is cholecystolithiasis without acute complication. The risks associated with this new technique justify a careful selection of its indications and make it imperative for the operator to be a surgeon with wide experience of biliary tract surgery. Author-abstract.

18
AN 89264119. 89000.
AU Chattopadhyay-T-K. Kumar-A. Kapoor-V-K. Sharma-L-K. Kapur-M-M. Kapur-B-M. Dhawan-I-K.
TI Carcinoma of the gall bladder — can we do anything?
SO Postgrad-Med-J. 1988 Aug. 64(754). P 593-5.
LG EN.
EN A retrospective review of 143 cases of carcinoma of the gall bladder is presented. The disease was more common in females in the 5th and 6th decades. Pain, anorexia, weight loss and jaundice were the common presenting symptoms, and hepatomegaly and palpable gall bladder the common signs. Laboratory and radiological investigations were merely confirmatory as the diagnosis in a majority of the cases was clinically obvious. Aspiration cytology and laparoscopic biopsy were of help in obtaining histological diagnosis. Only 47 patients were considered fit enough to undergo laparotomy. In a majority of these patients biopsy alone was possible while palliative procedures were performed in the others. The operative mortality was 18% even in this selected group of patients, due to the poor general condition and the advanced stage of the disease at the time of diagnosis. Curative resection may be possible and long term survival is expected in incidentally found carcinoma at cholecystectomy. The only hope lies in prevention by prompt treatment of patients with benign biliary disease. Author-abstract.

19
AN 88322010. 88000.
AU Moscovici-W-G. Marks-J-O. McSherry-C-K.
TI An experimental model for the combined medical and surgical treatment of gallstones.
SO Surg-Endosc. 1988. 2(2). P 66-70.
LG EN.
AB New approaches to the treatment of gallstone disease have been introduced in recent years. In addition to bile acid dissolution, a chemical solvent (methyl tertiary-butyl ether) has been instilled directly into the gallbladder by percutaneous transhepatic techniques. Shock wave fragmentation of stones, induced by extracorporeal techniques or contact catheter probe placement, have also been successfully employed. Recurrence of gallstones, however, can be anticipated in most of these patients with an intact gallbladder and continued hepatic production of lithogenic bile. In order to explore these new procedures and to attempt to find a solution to the problem of stone recurrence, an animal model has been developed. The essential components of this model consist of an endoscopic (laparoscopic) cholecystopexy and, at a later date, percutaneous re-entry into the gallbladder by dilation of the cholecysto-cutaneous tract and the use of electrohydraulic and ultrasonic lithotripsy and methyl tertiary-butyl ether to achieve stone dissolution. Author-abstract.

20
AN 87304038. 87000.
AU Orlando-R. Lirussi-F. Okolicsanyi-L.
TI Validity of laparoscopy after abdominal surgery.
SO Endoscopy. 1987 Jul. 19(4). P 150-2.
LG EN.
AB The authors carried out a retrospective study to investigate the effect of previous abdominal surgery on the validity of laparoscopy. Laparoscopy was done in 2,000 patients with liver disease, between 1976 and 1985. Of these, 250 (12.5%) had undergone abdominal operations, and all presented with intraperitoneal adhesions. The whole surface of the liver was visible in 45.3%, but only in part in 46.2% of patients with upper abdominal operations (cholecystectomy, gastric surgery). Lower abdominal surgery (appendectomy, gynaecological operations) was associated with complete visibility of the liver in 97.5% of the cases. Laparotomy was followed by the highest incidence of non-visibility of the liver (28.5%). In the other 1,750 patients without abdominal operations, adhesions were detected only in 83 (4.1%) and the liver was entirely observable in 83.1% of these. In conclusion, previous abdominal surgery does not represent an absolute contraindication to laparoscopy, since risks are not as great as one might suppose. Although the view of the liver is sometimes impaired, laparoscopy retains its role in the assessment and therapy of liver disease, and avoids complications related to blind biopsy of the liver. Author-abstract.

Dominique-Jean Larrey: Napoleon's Surgeon from Egypt to Waterloo

Miguel A. Faria, Jr., M.D.

Dominique-Jean Larrey (1766-1842)[1]

PRAISED BY Napoleon as "the worthiest man I ever met," Dominique-Jean Larrey (1766-1842), his legendary surgeon, was born in Beaudean, a little village in the Pyrenees. Orphaned at age 13, he was raised by his uncle, Alexis, who was chief surgeon at Toulouse. After studying and serving as his surgical apprentice for 6 years, Larrey went to Paris. There, he studied under the great French surgeon, Desault, who was Chief of Surgery at the Hotel Dieu. Unfortunately, his studies were interrupted when war came to France.

The young man promptly answered his nation's call and signed up for duty. He was assigned to the frigate *Vigilante* in the French Navy, but he soon had to resign because of chronic seasickness. He returned to Paris where he worked at both Desault's clinic in the Hotel Dieu and as field surgeon at *Les Invalides*. By 1790, Larrey had established himself as assistant Senior Surgeon at *Les Invalides*, and not long after serving in the army, he met Napoleon Bonaparte who was then commander of an artillery brigade.

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This article is dedicated to the surgical staff of HCA Coliseum Medical Center in Macon. The author also acknowledges his office staff and surgical team in the operating room for their encouragement in his surgical endeavors.

In 1792, at the time revolutionary France was battling the First Coalition, Larrey became a field doctor with the rank of Major of the Army of the Rhine. He soon recognized the need for better organization in the battlefield, as victims died before they could receive any medical assistance. It was during this period of the French Revolutionary Wars that he thought of his celebrated *Ambulance Volante* or "the flying ambulances."[1] The flying ambulances were horse drawn wagons for collecting and carrying the wounded from the battlefield to base hospitals. He described this concept in minute detail in a report from the Italian Campaign of 1797. It consisted of a system of transport of medical supplies and supporting personnel. The personnel included a doctor, quartermaster, noncommissioned officer, a drummer boy (who carried the bandages), and 24 infantrymen. The flying ambulances were a success, and this idea was subsequently taken up by other armies.

After Waterloo, Larrey was captured and imprisoned by the Prussians and quickly given a death sentence . . . but Fortune intervened. . . .

Larrey was soon organizing flying ambulances for the entire French Army. This transport system served not only as a boost in morale for the rank and file officers of the French Revolutionary Armies, but it also effected a greater and realistic opportunity for the treatment and survival of the wounded. Moreover, his attention to the wounded on *both* sides of the battlefield was a noble concept for which Larrey should be credited. These revolutionary ideas for the care of the wounded survived to modern times in the form of the Red Cross.*

During the brief peace that followed the Italian campaigns of 1797, he became Professor of Surgery at the military hospital of *Val-de-Grace* where his statue still stands. He was given great recognition for his achievements, and Napoleon appointed him Chief of the Medical Corps during the planning of the forthcoming Egyptian campaign (1798-1799).

In Egypt and the Middle East,** despite enormous hardships, Larrey's indefatigable energy served him well. He built military hospitals in Egypt, Sudan, Syria, and Palestine. It has been said that even in the harsh desert terrain, his flying ambulances would collect the wounded in less than 15 minutes. Not only did he prove his administrative skills but also his practical abilities — at Accra (1799) he himself performed 70 amputations and seven trepinations. He also found time to write about endemic diseases such as typhus, bubonic plague, leprosy, and trachoma.

Upon returning from the Egyptian campaign (August 1799), he was made a baron by Napoleon and chief surgeon of the Emperor's Imperial Guard. He followed Napoleon in every campaign including Austerlitz (1805), Moscow (1812), and even accompanied the Emperor after his escape from Elba through "the hundred days" and to Waterloo (June 18, 1815). He served honorably in 25 major campaigns including 60 large battles during the revolutionary and Napoleonic wars. It has been said that the Duke of Wellington observed and commended him for his energy and valor in tending the wounded during the Battle of Waterloo.

During the War in Spain (1808), Larrey had ample opportunity to study leg amputation. The Spaniards mined the roads of retreat resulting in a large number of casualties and lower extremity injuries. As senior field doctor in both Corsica and Spain, he learned and perfected his technique of leg amputation as well as the treatment of frostbite. This experience was later to prove valuable in the disastrous Russian campaign of the winter of 1812.

Dr. Larrey recognized the need for better organization in the battlefield, as victims died before they could receive any medical assistance. He developed "flying ambulances," horse drawn wagons for collecting and carrying the wounded from the battlefield to base hospitals.

It was during this retreat from Moscow that Larrey also observed that those legs frozen stiff felt almost no pain during amputation. Moveover, after amputation, pain was diminished by packing the stumps in ice and snow. He put this knowledge to good use to alleviate the suffering of those wounded.

It was Larrey's skills in amputations for which his name is still re-

*This tribute to Larrey does not detract from the credit due to the Swiss humanitarian Jean Henry Dunant (1828-1910) for the founding of the Red Cross.[2]

**Where Napoleon fought and won the Battle of the Nile in July 1798 but lost the battle of Abakir Bay with the destruction of the French fleet by Admiral Nelson on August 1, 1798.

membered. It has been said that he himself performed 200 amputations within a 24-hour period after the Battle of Borodino in 1812. At the Battle of the Berezina during the disastrous retreat from Russia, he performed 300 more amputations. He was revered by the men in the ranks. At the almost impassable Berezina River, they passed him over their heads from man to man to safety.[3] He also performed the first hip joint amputation in 1803. An interesting account of a woman who underwent a mastectomy by the Baron at her home in 1810, recently appeared in the surgical literature.[4] Noteworthy in the account is the woman's adoration for her surgeons, especially Dr. Larrey, despite her ordeal (no anesthesia) and in turn, the Baron's compassion for his patient.

He followed Napoleon in every camapaign including Austerlitz (1805), Moscow (1812), and even accompanied the Emperor after his escape from Elba through "the hundred days" and to Waterloo (1815).

For the care of wounds, Larrey substituted wet dressings for the dry lint used mainly at that time. He dipped his lint in hot wine to which he added camphor. For the first time, bullets were extracted from wounds by making a counteropening instead of probing the torn entry path of the bullet. Also, prophylactic incisions were made near bayonet wounds to let the pus flow out.[5] Larrey was also credited with saving three victims of penetrating chest injuries during the Napoleon war . . . — up until the 20th century, there was little hope for injuries that penetrated the pleural cavity. He has also been reported to have saved a man with a self-inflicted stab wound to the heart. Because of this and other great accomplishments, he was highly respected by friends and foes alike. He was adored by the public and much admired by his colleagues while living in one of the most turbulent times of history. His name has been overshadowed by other French contemporary health professionals who were given a place in history because of their political notoriety. Chiefly, among these figures stand the chemist Antoine Lavoisier and the physicians Joseph Guillotin and Jean Paul Marat.*

After Waterloo, the Baron was captured and imprisoned by the Prussians and quickly given a death sentence. Fortunately for the good doctor, he was recognized by a German physician who had been his student at *Val-de-Grace*. He pleaded for Larrey's life with Marshal Blücher. Fortune indeed intervened: Blücher's son had once been wounded in a skirmish and taken prisoner by the French. As it turned out, his life had been saved by Dr. Larrey. The Baron was released and returned to France with a Prussian escort.

Later in his career, he was the most popular surgeon of his time and in his old age, he enjoyed a comfortable life, writing his memoirs which were invaluable to later medical researchers as well as historians. Recognizing his personal physician and loyal friend, Napoleon, while exiled on the island of St. Helena, is reputed to have said, "Larrey was the most honest man and the best friend to the soldier that I ever knew."[7] In his testament, the Emperor rewarded his courageous surgeon: "To the French Army's Surgeon General, Baron Larrey, I leave a sum of 100,000 francs. He is the worthiest man I ever met."[1]

It was Larrey's skills in amputations for which his name is still remembered. He performed 200 amputations within a 24-hour period after the Battle of Borodino in 1812.

*Dr. Antoine Laurent Lavoisier, a founding father of modern chemistry, discovered the role of oxygen in combustion and metabolism. He also was the initiator and proponent of the metric system of weights and measurements which was adopted by the French Revolutionary Convention in August 1793.[6] Lavoisier was hurried to the scaffold complaining that he had not been given enough time to finish a paper on chemistry. He, like many other aristocrats, was beheaded during The Terror.

Dr. Joseph Ignace Guillotin was the professor of anatomy who devised the macrotome that bears his name. To the guillotine, 20,000 men, women and children lost their heads during the Reign of Terror (June 1793-July 1794). Dr. Guillotin survived the contraption of his invention as well as the French Revolution.

Lastly, Jean Paul Marat was the most famous physician of the French Revolution. He was stabbed to death in his bath on July 13, 1793, by a young woman seeking revenge for her father's death. He had been a political enemy of Marat. She followed her father to the guillotine for her revenge.

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MRI UPDATE

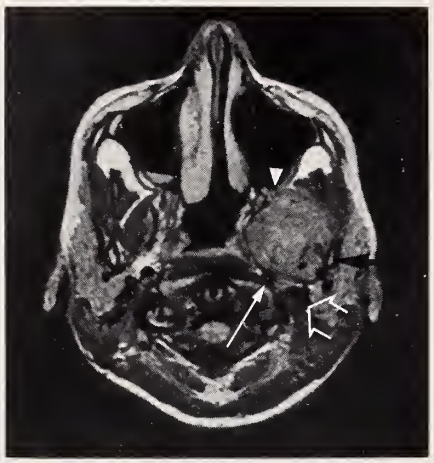

Figure 1

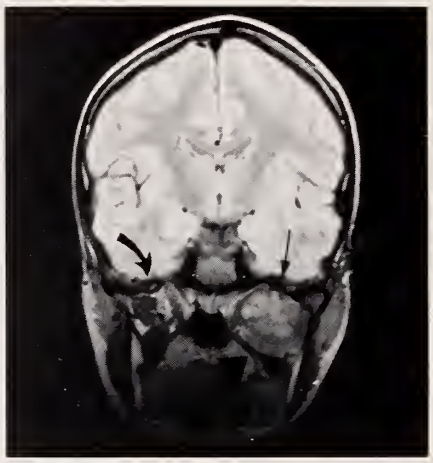

Figure 2

CLINICAL INFORMATION: This is a 14-year-old male with headache and left jaw pain.

FINDINGS: The axial image (figure 1) demonstrates a 4 cm. mass centered in the left parapharyngeal space. It deforms the left nasopharyngeal wall, but the fat plane between the nasopharyngeal wall and the mass indicates that the mass did not arise from epithelium there. The mass extends anteriorly through the pterygopalatine fossa to abut the posterior wall of the maxillary sinus (arrowhead), but it does not appear to invade the sinus. The mass extends laterally adjacent to the neck of the mandibular condyle (large arrow). It is separated from the deep lobe of the parotid by the deep branch of the facial artery. The mass is separated by fat from the internal jugular vein (open arrow). It abuts, but does not encase the internal carotid artery (long arrow). The coronal image (figure 2) demonstrates the mass effect of this large lesion (large arrow). Though the mass lies adjacent to the foramen ovale (small arrow) and appears to engulf an exiting branch of the mandibular nerve, it does not extend intracranially. The mandibular division of the fifth nerve lying just above the foramen ovale is shown on the normal right side (curved arrow).

COMMENT: MRI clearly demonstrates the size and extent of the mass in this difficult location. CT does not provide the multiplanar capability and soft tissue detail afforded by MRI which provides complete presurgical staging and analysis. The differential diagnostic possibilities must include juvenile angiofibroma because of the patient's age and sex. Paraganglioma and schwannoma were also considered possibilities. Mixed tumor arising from the deep lobe of the parotid could produce this appearance, but the lesion appeared to be separate from the deep lobe. The biopsy diagnosis was "sarcoma". Rhabdomyosarcoma in this area more commonly occurs in younger children.

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Perestroika Meets Health Care

Henry S. Kahn, M.D.

THE SOVIET health care sector, like its other economic and political structures, is being challenged by *glasnost* and *perestroika*. Soviet health planners are openly considering the health care models and experience of other countries as they contemplate making major changes in the next few years. During 10 days in April I visited the USSR with a small team of American doctors and other academics invited to consult and interact with the Soviet health care planning process.

The Soviet constitution guarantees free medical care provided by state health institutions (Article 42, Constitution of 1977), yet many Soviet clinics suffer from inadequate equipment and medicines. Hospital services are widely perceived as being of poor quality. Despite the fact that the Soviet Union has 1.2 million doctors (over 1/3 the world's total) and over 3.7 million hospital beds,[1] its medical care has been increasingly critized by Soviet citizens since the 1970s.[2, 3]

Clinics and hospitals in Soviet Georgia were generally sparsely equipped and perhaps primitive by U.S. standards. . . . On the other hand, low-technology recuperative services were generous and comfortable.

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A frank report to the All-Union Congress of Doctors held in October, 1988, revealed that the infant mortality rate for the country as a whole rose from 24.7 per 1000 live births in 1970 to 27.3 in 1980. Although the overall rate had since declined to 25.4 by 1987, areas such as Uzbekistan, Tajikstan, and Turkmenia still have infant mortality rates above 40. Life expectancy, which had been 64.5 years for men and 73.6 for women in 1971-72, had dropped to 62.5 and 72.6 years, respectively, by 1978-79.[4]

Nearly all Soviet physicians work for a salary, but physicians' official incomes (exclusive of under-the-table private payments) are generally lower than the wages of industrial workers. The Soviet health care system received only about 4% of the Soviet GNP in 1987, as compared to nearly 12% of the U.S. GNP which goes to health care. Reform, if not revolution, is now widely expected in the structure and financing of Soviet medical care.

Early in our visit, we met in Moscow with Dr. Yuri Belenkov, a prominent research cardiologist who is also a member of the Supreme Soviet and Vice Chairman of its Committee on Public Health. Belenkov predicted that upcoming legislation would establish the right of certain medical institutions to charge for their services. This would generate needed additional revenues for health activities currently unavailable from the state budget. He pointed out, however, that stronger institutions would be able to attract larger shares of the private funds to the detriment of smaller or weaker institutions. Hospitals would likely siphon resources away from primary, out-patient, or preventive care. In a subsequent 3-hour exchange with 10 members of the Supreme Soviet, most of them senior health care professionals, we heard similar themes. The major requirement, in their view, was to supplement public health care expenditures with non-public funds generated locally, through cooperative or private enterprises, or by other sources.

Nearly all Soviet physicians work for a salary, but physicians' official incomes are generally lower than the wages of industrial workers.

Our group then spent 4 days sequestered with a task force of economists and health planners at the Georgian resort of Kobuleti on the Black Sea coast. Dr. Alexander Telyukov, a young economist from the State Central Planning Agency (Gosplan), outlined an intricate proposal for enterprise-based "insurance medicine," including multiple carriers. His plan emphasized market mechanisms that would determine prices and a heavy reliance on non-governmental activity to regulate medical resources. Premiums derived from enterprises (businesses) could be adjusted according to local circumstances such as occupational hazards and climate. Special provisions would have to be made for citizens who were not associated with enterprises, such as pensioners, workers in "budgetary institutions" (government agencies), students, and the unemployed.

Dr. Igor Sheiman, another young economist, emphasized the voluntary nature of this proposal for health care enhancement through the insurance mechanism. He pointed out that there would still be a mandatory territorial (public) system providing basic services of both medical care and public health. Companies involved in the production of new drugs or needed medical supplies might receive generous tax breaks over several years in order to help them attract capital.

Numerous additional perspectives were offered by sociologists, doctors, and planners from various parts of the Soviet Union. Several of them had already been involved in local experiments with alternative models of medical service delivery.

The American group made presentations about the contemporary problems with medical care in the United States, despite our much larger expenditures in the health sector. If the affluent, but largely private, system of U.S. health care was still failing to meet the needs of many Americans, it seemed to us that privatization of the less affluent Soviet health care system could lead to serious inequities and a dangerous diversion of resources away from public health.

Our group took time to visit a variety of medical facilities in nearby towns of Soviet Georgia. Clinics and hospitals were generally sparsely equipped and perhaps primitive by U.S. standards, although the hospitality of our many hosts was extraordinary. On the other hand, low-technology recuperative services (including the workers' sanitarium in which we stayed for 4 days) were generous and comfortable. We saw evidence of new attention to issues such as ecologic preservation and smoking cessation, both of which are sorely needed for the improvement of Soviet health. There was little interest shown, however, in promoting a low-fat or low-salt diet. The recent campaign against heavy alcohol consumption appears to have been stalled.

On return to Moscow we presented a synthesis of our impressions to the Ministry of Health. We also met several times with Professor Alexander Kiselev and his staff at Soyuzmedinform, the Health Ministry's 2-year old institute for medical information, to outline a USSR-USA Health Policy Exchange Initiative.

Our two great countries are simultaneously facing health care crises, but from very different origins and perspectives. Many Soviet citizens face medical care deprivation largely due to underinvestment in health. Many American citizens lack medical care primarily due to the distortions brought about by a costly private system. Neither country yet does well in providing preventive services or a healthy environment. Soviet and U.S. health planners should learn a lot from each other as each country struggles to improve its health care system.

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The National Practitioner Data Bank: Critical Points to Remember

Editor's note: Congress has created the National Practitioner Data Bank to collect and release certain information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. The Data Bank will be operated by Unisys Corporation under contract from the Secretary of HHS. Originally intended to open last April, the Data Bank will begin operation September 1, 1990.

Here, summarized from the recently published AMA booklet, "National Practitioners Data Bank," are its basic provisions. (For further information, refer to the March, 1990, issue of the Journal *which featured an article in the LEGAL Section, "Dealing With the New National Practitioner Data Bank," by Robert N. Berg, or contact the* Journal *office for a copy.)*

Four Actions to Be Reported To the Bank

1. ***Medical Malpractice Payments***
   Each person or entity, including an insurance company, which makes a payment for medical malpractice on behalf of any licensed physician as the result of a written claim or judgment *must* report information to the Data Bank and State Board of Medical Examiners. If a physician makes a payment to a patient as a result of a claim or judgment, the physician is responsible for filing a report with the Data Bank and state medical board.

2. ***Licensure Actions Taken by Boards***
   State Board of Medical Examiners *must* report to the Data Bank any disciplinary action based on reasons relating to a physician's professional competence or professional conduct.

3. ***Clinical Privilege Actions***
   Hospitals and other health care entities *must* report to their State Board of Medical Examiners when certain adverse actions are taken against a physician's clinical privileges.

   Each hospital or health care entity must report the following clinical privilege actions:

   - Any professional review action that results in denial, revocation, suspension, limitation, or reduction of the clinical privileges of a physician for a period longer than 30 days.
   - Acceptance of the surrender or restriction of clinical privileges by a physician while under investigation by the hospital or health care entity.

4. ***Society Membership Actions***
   Professional societies of physicians which engage in professional review activity through a formal peer review process for the purpose of furthering quality health care *must* report adverse membership actions to the Data Bank.

The Physician's Right to Query The Bank

Every physician can periodically request a copy of his or her Data Bank file, and this information will be sent at no charge to the physician. If the physician has never received notification of a report being filed, no adverse information will be on file concerning him or her in the Data Bank.

Other Authorized Inquirers

1. ***Plaintiff's attorney***
   A plaintiff's attorney or *pro se* plaintiff who has filed a professional liability action or claim against a hospital and specific physician(s) may query the Data Bank for information regarding a specific practitioner who is named in the action against the hospital. However, this is only when there is evidence that the hospital failed to make a mandatory query from the Data Bank regarding the practitioner(s) named in the action or claim. Further, the information obtained from the Data Bank on the practitioner can only be used with respect to the action or claim against the hospital, and not against the practitioner.

2. ***Hospitals***
   Each hospital *must* request information from the Data Bank when a physician applies for medical staff membership or clinical privileges, and every 2 years while the physician is on its medical staff or has clinical privileges. Hospitals may also request information from the Data Bank at any time they deem it necessary.

3. ***State licensing boards.***

4. ***Health care providers with a formal peer review process.***

5. ***Professional societies with a formal peer review process.***

Disputing Data Bank Information

When a physician believes that the information in a report filed with the Data Bank contains inaccurate or incomplete information, he or she should attempt to resolve the problem through discussion with the entity which reported the information.

The physician has 60 days (from the date the Data Bank processed the report) to dispute the accuracy of information contained in the report.

In order to dispute the information, the physician must:

- Sign, in the appropriate space, the Practitioner Notification document received from the Data Bank to inform the Secretary of Health and Human Services of the physician's disagreement with the report, and request that the report be entered into a "disputed" status.
- Describe in writing on the Notification Document the reason for the disagreement with the report (e.g., incorrect or incomplete information).
- Return the Notification Document to the National Practitioner Data Bank, P.O. Box 6048, Camarillo, CA 93011-6048. If the physician wishes to send the report by certified registered mail, address it to: National Practitioner Data Bank, 5151 Camino Ruiz, Mail Drop E-102, Camarillo, CA 93012.
- Inform the reporting entity in writing of the disagreement with the report and the basis for it.
- Attempt to discuss the situation with the reporting entity to resolve the dispute.

Confidentiality of Data Bank Files

The information contained in the Data Bank is confidential and intended for authorized entities only. Any person who violates the confidentiality provisions shall be subject to a civil penalty of up to $10,000 for each violation. The Office of Inspector General is responsible for enforcing the confidentiality provisions of the HCQIA.

For More Information

- The MAG has developed a voluminous store of information for the bank, including publications from the AMA, videotapes, and the Bank itself. Please contact Steve Davis at the MAG office for copies of these key documents.
- The National Practitioner Data Bank in Rockville, MD, may be reached by phoning 800-767-6732. More information is also available through:
  John Rodak, Jr., Project Officer
  Division of Quality Assurance and Liability Management
  Health Resources and Services Administration
  Room 8-67, Parklawn Building
  5600 Fishers Lane, Rockville, MD, 20857; 301-443-2300.

New Techniques for Percutaneous Coronary Artery Revascularization

John S. Douglas, Jr., M.D.

Introduction

THE REALIZATION that one can safely work within the coronary arteries using percutaneous techniques stimulated medical inventors, entrepreneurs, and the medical device industry to produce an array of new strategies directed at non-surgical coronary artery revascularization. Both the successes and failures of coronary artery balloon angioplasty have heightened the intensity of these efforts. That coronary artery balloon angioplasty has been immensely successful, few would disagree (see "The Current Status of Coronary Artery Balloon Angioplasty" in the August, 1990, HEART section of the *Journal*). However, significant problems remain. It is frequently impossible to recanalize totally occluded coronary arteries using current balloon angioplasty techniques. In addition, arterial dissections and abrupt occlusion at the time of the procedure and restenosis within 6 months remain significant limitations. Exactly how the new wave of cutters, intra-coronary scaffolding devices, hot balloons, shavers, and lasers will ultimately be applied in invasive cardiology practice remains to be seen.[1] At least four of the new techniques appear to offer some unique advantages, which may gain them a place in mainstream practice; these are atherectomy, the excimer laser, laser balloon angioplasty, and intracoronary stents.

Atherectomy

Currently available atherectomy devices permit plaque removal from proximal coronary artery sites in non-tortuous vessels, yielding an arterial lumen that is frequently larger and smoother than that achieved with conventional balloon angioplasty. Eccentric and ledge-like lesions, which respond poorly to balloon angioplasty, can be shaved off and subjected to histologic analysis. Coronary atherectomy complication rates in the first 1500 patients treated were similar to conventional angioplasty. Preliminary data on restenosis have been somewhat disappointing, but certain patient subsets (short virgin lesions, ostial sites) appear to have a lower restenosis rate than with balloon angioplasty.[2] The observation that the presence of arterial media in atherectomy specimens was associated with a higher restenosis rate has altered practice toward a less aggressive approach, with less tissue removal. We have found atherectomy to be invaluable in a few patients who had lesions that were unfavorable for or who failed conventional balloon angioplasty.

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The HEART Section is sponsored by the Georgia Affiliate of the American Heart Association. We invite original contributions to this section. Please send them to Robert C. Schlant, M.D., HEART Section Editor, and Professor of Medicine (Cardiology), Emory University School of Medicine, 69 Butler St., SE, Atlanta, GA 30303.

"Exactly how the new wave of cutters, intra-coronary scaffolding devices, hot balloons, shavers, and lasers will ultimately be applied in invasive cardiology practice remains to be seen. At least four of the new techniques appear to offer some unique advantages and are discussed here."

Excimer Laser

The most widely used xenon chloride excimer laser emits a wavelength of 308 nm in the ultraviolet range, which disrupts molecular structure of arterial plaque with no thermal injury of the arterial wall. During over 1,000 coronary laser procedures

in the United States and Western Europe, the success rate has been approximately 90%, but 50% of the patients required adjunctive balloon angioplasty. With the development of larger diameter laser catheters, an increase in "stand-alone" procedures can be expected, and a more accurate estimate of the value of the technique will be possible.[3] Procedural safety is similar to conventional balloon angioplasty, except for a higher rate of arterial perforation (0.7%). The excimer laser appears to offer some advantages in long, calcified lesions and in ostial lesions of the right coronary artery in our experience.

"Although each of these new strategies has unique advantages which can be exploited in dealing with individual patient problems, all are more expensive and complicated and have more anatomic limitations than balloon angioplasty."

Stents

Virtually all of the clinical experience in this country has been obtained with balloon-mounted stainless steel coil or slotted tubular stents. Inflation of an angioplasty balloon expands the stent producing a cylindrical scaffolding that presses itself into and supports the arterial wall. These devices are particularly useful in stabilizing patients who experience coronary artery dissections and occlusions as a complication of balloon angioplasty. In over 40 patients in our hospital alone, stent placement has made it possible to avoid emergency by-pass surgery for failed angioplasty. Ongoing clinical and laboratory trials will determine the most favorable stent designs and material and establish the utility of stents as primary therapy.

Laser Balloon

In this technique, Nd:YAG laser energy is emitted circumferentially from an inflated angioplasty balloon. The laser energy heats the arterial wall to approximately 95° C. The combination of heat and pressure welds vascular tissue and blunts elastic recoil producing, in effect, a biologic stent. Although the immediate results with this device appear superior to conventional balloon angioplasty, restenosis rates have been similar. Further studies are needed to determine restenosis rates at lower laser doses. In our experience, laser balloon angioplasty has been especially helpful in treating patients with arterial dissection, achieving results similar to those obtained with stents, but without implantation of a permanent, metal device.[4]

Although each of these new strategies has unique advantages which can be exploited in dealing with individual patient problems, all are more expensive and complicated and have more anatomic limitations than balloon angioplasty. Each device and technique continues to undergo modifications that improve outcome and safety. Evaluation of new generations of "plaque busters" will be an ongoing process for years to come.

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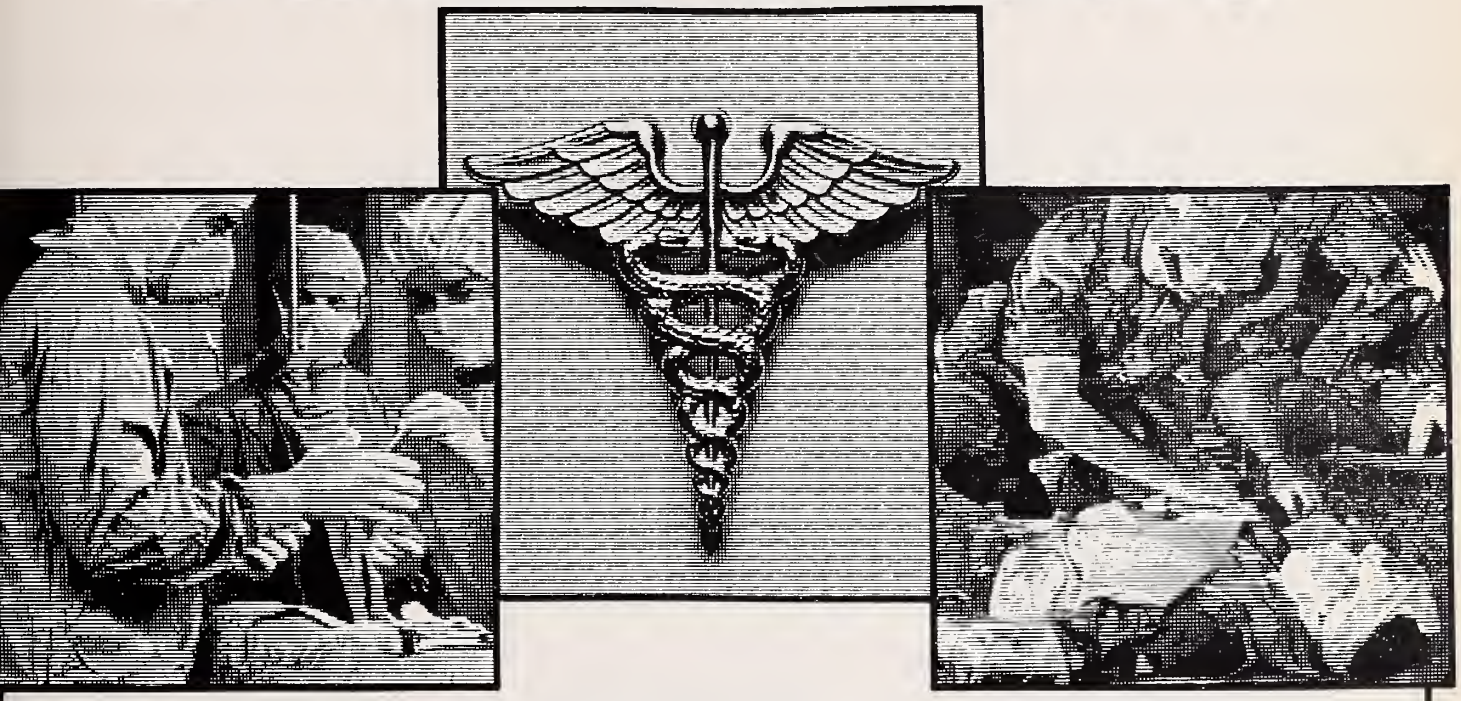

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Clarification Regarding August Legal Section Article

LAST MONTH'S Legal Section article, "MAG Adopts Model Medical Staff Bylaws" by Richard H. Vincent, Robert N. Berg, and Susan C. Atkinson, stated that Model Medical Staff Bylaws had been adopted by the MAG Board of Directors at the June, 1990, meeting. This is inaccurate. The Model Bylaws were adopted in concept, with subsequent modifications (to be approved by the Hospital Medical Staff Section Committee and MAG General Counsel, Richard Greene) to lead to a final draft requiring formal adoption by the Executive Committee.

Advance Medical Directives: Durable Power of Attorney for Health Care Act

Thomas E. Wallace, M.D., J.D., F.C.C.P.

A COMPETENT adult patient legally may refuse medical treatment, in the absence of conflicting state interests.[1] Generally, there are four recognized state interests that must be balanced with, and may override, the competent adult's right to refuse treatment: (1) preserving life, (2) preventing suicide, (3) preserving the integrity of the medical profession, and (4) protecting innocent third parties. For example, in *Jefferson v. Griffin-Spalding Hospital Authority,*[2] the Georgia Supreme Court ordered a mother to undergo a Caesarean section to save the life of an innocent third party, the mother's unborn child, in spite of the mother's refusal to consent on religious grounds.

When the adult patient is competent and understands the general nature of the medical treatment he or she is considering or refusing, there is no problem as the patient exerts his or her own rights. But when the patient is incompetent, either through illness, anesthesia, or injury, a problem arises in deciding the wishes of the patient.

The United States Supreme Court recently upheld Missouri's refusal to remove a feeding tube at her parents' request from Nancy Cruzan, who was in a persistent vegetative state for years, due to a lack of "clear and convincing proof" of Nancy Cruzan's desires.[3] With the *Cruzan* decision, the importance of giving clear advance directives for one's own health care is now vital.

"This Act will provide a mechanism for patients to give advance medical directives regarding all aspects of their health care for the times that they are incapacitated or incompetent."

The Georgia General Assembly has addressed this problem first by the passage of the Georgia Medical Consent Law, then the Living Will Act and, most recently during its 1990 session, by enacting the Durable Power of Attorney for Health Care Act. Each of these Acts is distinct, and needs to be understood in context.

This article was prepared at the request of the *Journal*. Dr. Wallace is a practicing pulmonary and critical care physician who recently earned his J.D. degree from Georgia State University School of Law.

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Georgia Medical Consent Law

The Georgia Legislature passed the Georgia Medical Consent Law in 1971.[4] This Act allowed an adult person to consent to medical treatment for himself, and empowered other persons who could consent to treatment when the patient could not consent for himself.[5] However, when the decision is one regarding withdrawal of sustaining life-support equipment, the decision becomes difficult, as the physician has a duty to carry out the patient's desires regarding treatment. This is not a problem when the patient is a competent adult and understands the treatment. But if a patient becomes incapacitated or incompetent, then the patient must express his wishes before becoming incapacitated or incompetent for the health care provider or the courts to know the wishes of the patient. If the patient's wishes are unknown, a dilemma exists for the health care provider, the family, and the courts who must try to decide what the patient would want in this situation.

Georgia Living Will Act

In 1984, the Georgia Legislature passed the Living Will Act[6] in response to the public demand for a way to make known their wishes concerning artificial life support. A living will is executed

while the individual is still competent to make medical decisions. The living will in Georgia allows a person to specify that if that person has a "terminal condition,"[7] then life support devices may be removed, and all treatment except nourishment and medication or procedures to alleviate pain may be stopped. The Georgia Living Will Act, similar to the Missouri law upheld in the *Cruzan* case, does not apply to a patient suffering from persistent vegetative state nor does it authorize withdrawal of a feeding tube.

Durable Power of Attorney for Health Care Act

Through the combined efforts of the Medical Association of Georgia, the Georgia Hospital Association, and the Georgia State Bar, the Georgia Legislature passed the Durable Power of Attorney for Health Care Act in its 1990 session.[8] The Act became effective July 1, 1990.[9] At least 25 states have specific power of attorney for health care statutes now, and a few others recognize this power of attorney in case law.

Powers of attorney for persons regarding financial matters and for property have long been authorized in Georgia. Still, there was some question whether this power also could cover health care decisions, inasmuch as "the powers concerning health care decisions are more sensitive than property matters [such] that particular rules and forms are necessary for health care agencies to ensure their validity and efficacy and to protect health care providers so that they will honor the authority of the agent at all times."[10] Accordingly, the General Assembly recognized the right of the individual to control most aspects of his or her medical treatment.[11] This Act allows an individual to delegate to a trusted "agent" the decision-making power to make personal and health care decisions, with the same effect as if the individual made the decisions, while giving advance directives regarding his or her wishes in certain circumstances.

"The delegation of authority by the principal is a broad one, allowing the agent to make any medical decision that the principal could have made if legally competent. If the principal is legally competent as judged by the attending physician based on the physician's good faith judgment, then the agent lacks authority."

1. What is a Durable Power of Attorney?

A power of attorney is a means by which a person (the "principal") can authorize another person (the "agent") to take action on the principal's behalf that is legally binding. The agent can be a family member, friend, employee, or any other competent adult. The agent need not be a lawyer. With an ordinary power of attorney, when the principal becomes incompetent, the agent is incompetent to act on the principal's behalf. Therefore, to correct this deficiency, states have enacted "durable" power of attorney statutes, under which the agent's authority remains or takes effect when the principal becomes incompetent.[12] In the Georgia Act, the authority carries through the period of incompetency and past the principal's death, permitting anatomical gifts, autopsy, or disposition of remains.[13]

2. How is a Durable Power of Attorney for Health Care Created?

Under the Act, only competent adults 18 years of age or older can create this durable power of attorney. The agent also must be a competent adult at least 18 years of age, as must be the two required witnesses to the durable power of attorney. The principal's signature creating the durable power of attorney for health care must be witnessed by the witnesses, and so attested by the witnesses. (There is no restriction, other than age and competency, on who can be a witness.) The agent cannot be a person who is a health care provider directly or indirectly involved in the health care of the principal. Health care providers not involved in the health care of the principal may serve as agents.[14]

If the form is signed in the hospital, then the attending physician must attest that the principal is of sound mind and has made the health care agency decision willingly and voluntarily. The form of the durable power of attorney for health care is set forth in the statute, and includes

several standard directives regarding life-sustaining or death-delaying treatment from which the patient may choose. However, any similar form is acceptable.[15]

The responsibility for communication of the durable power of attorney for health care belongs to the principal and the agent. Once notified of the agency, the health care provider must place a copy of the agency in the patient's medical records.[16]

The durable power of attorney for health care decisions may be revoked at any time by the principal by destroying the durable power of attorney, by divorce if the agent is the principal's ex-spouse, by written revocation, or by oral expression of intent to revoke the agency.[17]

3. What Powers May be Provided to the Agent?

The delegation of authority by the principal is a broad one, allowing the agent to make any medical decision that the principal could have made if legally competent. If the principal is legally competent as judged by the attending physician based on the physician's good faith judgment, then the agent lacks authority. Physicians judge competency by the patient's ability "to understand the general nature of the health care procedure being consented to or refused."[18] But when the principal is not competent, then the agent is under a duty to act according to the wishes of the principal as if the principal were making the decision. This obligation holds whether the principal's intent and desires are expressed in writing in the delegation of power or in other ways by the principal before the principal became incompetent.[19] The form incorporates certain treatment decisions to help ensure that a patient's instructions are specified.

When the principal is incompetent, the agent can consent to or refuse any and all types of medical care, treatment, or procedures, except the agent cannot consent to psychosurgery, sterilization, or involuntary hospitalization on behalf of the patient. The agent can admit and discharge the patient, contract for health care services, examine and copy the patient's medical records, and, following death of the patient, direct an autopsy or disposition of the principal's body.[20]

"When the health care provider acts in good faith reliance on any decision by the agent on behalf of the patient that is not clearly contrary to the terms of the health care agency, then the health care provider is immune for civil or criminal liability."

4. Are Health Care Providers Immune from Liability?

In most cases, the health care provider must comply with the health care agent of the patient; the provider can administer treatment for the patient's comfort or alleviation of pain without the agent's consent. Also, if the health care provider is unwilling to comply with the agent's decision, the provider can inform the agent, and the agent may make other arrangements or transfer the patient.[21]

When the health care provider acts in good faith reliance on any decision by the agent on behalf of the patient that is not clearly contrary to the terms of the health care agency, then the health care provider is immune from civil or criminal liability.[22] The agent is afforded the same immunity if the agent acts in good faith and with due care for the benefit of the patient. If the patient's death results from withholding or withdrawing life-sustaining treatment, the death is not considered suicide nor homicide for any purpose.[23]

However, any person who, without the principal's consent, "willfully conceals, cancels, or alters a health care agency" or forges or falsifies the agency, may be held civilly liable. If a person falsifies or forges a health care agency with the intent to cause a withholding or withdrawal of life-sustaining procedures, that person may be subject to prosecution for criminal homicide. Also, any person who requires or prevents execution of a health care agency as a condition of any type of health care services to the patient may be held civilly liable and guilty of a misdemeanor.[24]

5. What if a Patient Has Both a Durable Power of Attorney for Health Care and a Living Will?

If a patient has both a living will and a durable power of attorney for health care, then the living will will not be operative while an agent authorized by the principal to make decisions regarding life-sustaining or death-

delaying procedures is available. The health care agent also has priority over any other person, including a spouse if the spouse is not the authorized health care agent, for all matters covered by the health care agency.[25]

Conclusion

The new Durable Power of Attorney for Health Care Act will provide a mechanism for patients to give advance medical directives regarding all aspects of their health care for the times that they are incapacitated or incompetent. The Act applies to more than just "terminal illness" as does the living will. Therefore, the durable power of attorney gives a broad power to the patient to control medical decisions in those times the patient cannot make those decisions for himself. These directives can be changed as often as the patient desires.

Physicians have a primary role in ensuring that patients consider the issue of artificial life support and their treatment preferences. Physicians should not wait until the onset of a severe illness to begin to discuss a patient's treatment preferences. Particularly since the *Cruzan* decision, patients should be encouraged to document their desires regarding these decisions, either by a living will or a durable power of attorney for health care. At least the physician should record in the patient's medical record the patient's wishes, as this information will help document the patient's wishes. The patient's wishes should be periodically reviewed, as patient's wishes may change with the passage of time or progression of his or her illness.

Notes

1. *See, In re L.H.R.*, 253 Ga. 439, 446, 321 S.E.2d 716 (1984); *State of Georgia v. McAfee*, 259 Ga. 579 (1989).
2. 247 Ga. 86, 274 S.E.2d 457 (1981).
3. *Cruzan v. Missouri*, 58 U.S.L.W. 4916, 4922 (s.c., June 26, 1990) (No. 88-1503).
4. O.C.G.A. §31-9-1 *et seq.* (1971).
5. O.C.G.A. §31-9-2 (1971).
6. O.C.G.A. §31-32-1 *et seq.* (1984) (later modified in 1986).
7. O.C.G.A. §31-32-1(10) (1984). "A 'terminal condition' means incurable condition caused by disease, illness, or injury which, regardless of the application of life-sustaining procedures, would produce death." *Id.* Two physicians who have examined the patient must certify in writing that (1) there is no reasonable expectation for improvement in the condition of the patient, and (2) death of the patient is imminent. *Id.*
8. Note, Health: The Durable Power of Attorney for Health Care Act, 7 Ga.St.U.L.Rev. (1990).
9. O.C.G.A. §31-36-12 (1990).
10. O.C.G.A. §31-36-2(b) (1990).
11. O.C.G.A. §31-35-2(a) (1990).
12. Orentlicher D. Advance Medical Directives. J.A.M.A. 1990;263:17.
13. O.C.G.A. §31-36-4 (1990).
14. O.C.G.A. §31-36-5(b) (1990).
15. O.C.G.A. §31-36-10(a) (1990).
16. O.C.G.A. §31-36-7(1) (1990).
17. O.C.G.A. §31-36-6(a) (1990).
18. O.C.G.A. §31-36-5(c) (1990).
19. O.C.G.A. §31-36-10 (1990).
20. O.C.G.A. §31-36-10 (1990).
21. O.C.G.A. §31-36-7(2) (1990).
22. O.C.G.A. §31-36-8 (1990).
23. O.C.G.A. §31-36-8(6) (1990).
24. O.C.G.A. §31-36-9 (1990).
25. O.C.G.A. §31-36-11 (1990).

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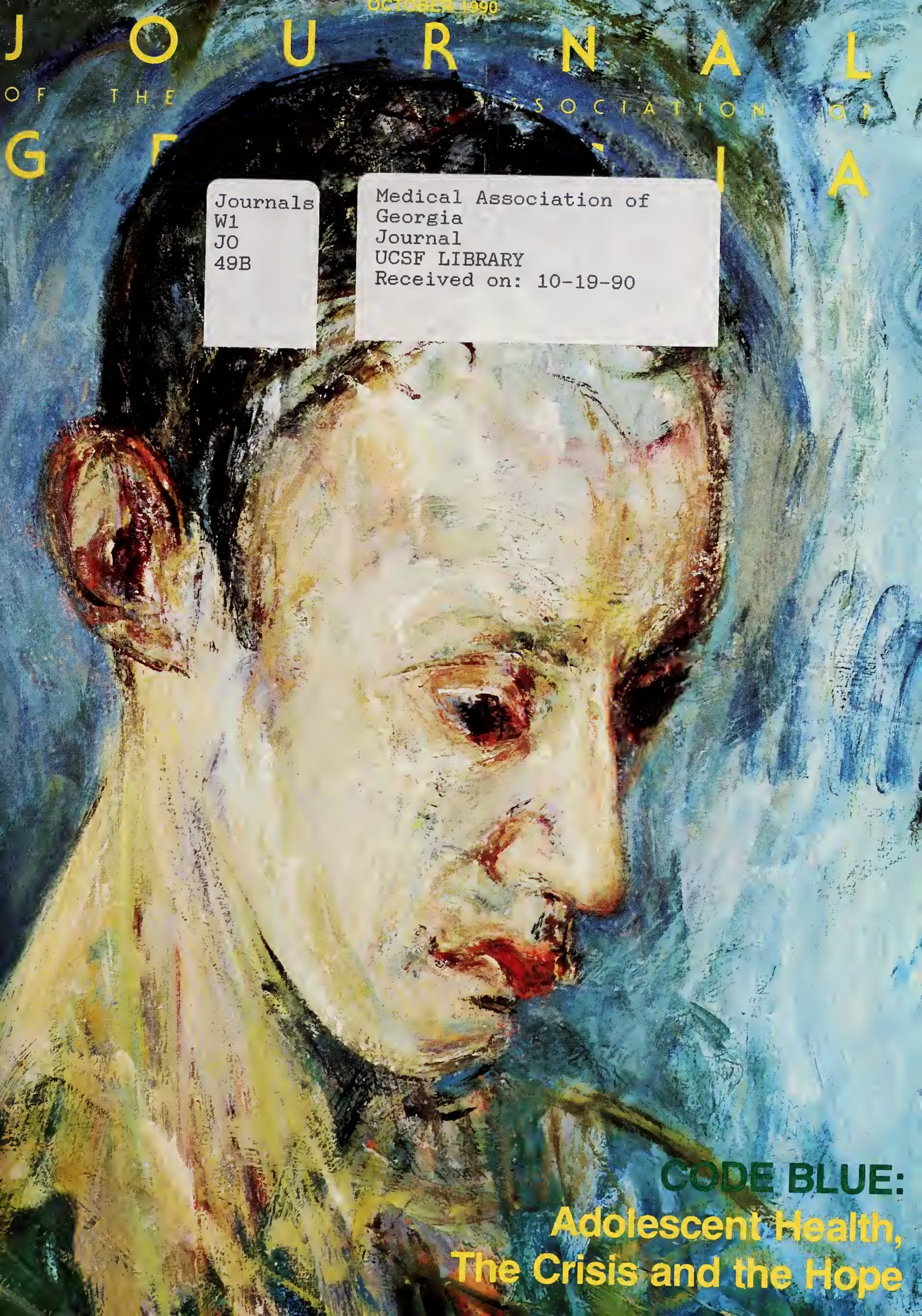

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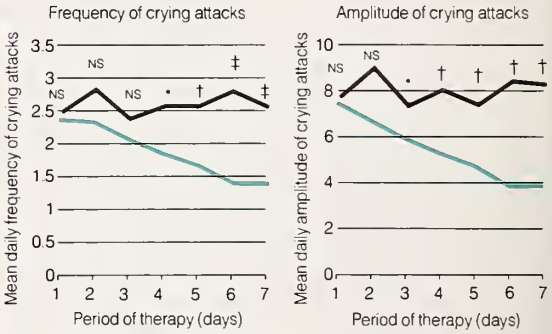

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THE COVER

Cover art by Haidee Becker, of London, England. Learn more about this exceptional artist on p. 722.

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Am Fam Phys 1987;36:133-140

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• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

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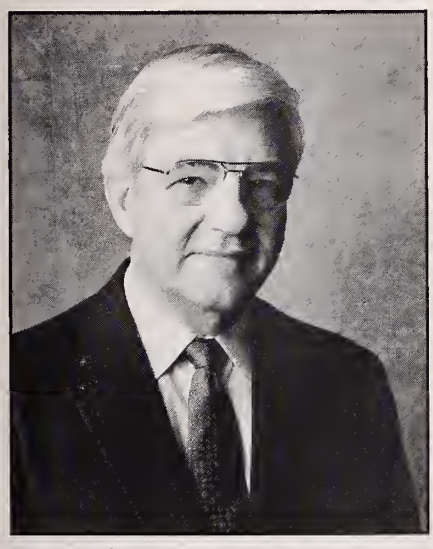

William C. Collins, M.D.

Jason and the Golden Fleece

RECENTLY, when Alan Nelson, who is the most recent Past President of the American Medical Association, was here in the Atlanta area, he began his speech with the question, "How many of you physicians in the audience would advise your children not to become a physician?" True to form, as across the country, approximately 25 to 30% of the audience raised their hands. This is a sad commentary, not only on the position of medicine in the large scheme of things from a prestige standpoint but also sadder still on what this portends for the American medical care system. This means that a large number of physicians have become so burdened with the hassle factors, insurance and government bureaucracy and the threat of the ubiquitous malpractice suit menace, that they have decided that the joys of practicing medicine do not outweigh the problems and disadvantages.

One of the saddest tales in classical Greek and Latin mythology is that of Jason and the Golden Fleece. Jason was an upright young man who originally set out to gain the throne that had been usurped from him and his father by his uncle Pelias. He was trained by the Centaurs so that he was equipped, both mentally and physically, for any of the hazards that the world or the superworld might put before him. Pelias, when confronted by the strong, youthful Jason, placed before him a challenge that intimated that he would give up his crown if Jason could bring back to Greece the Golden Fleece. This Fleece lay hanging on a tree somewhere in Asia Minor awaiting whoever might have the gumption and gall to attempt to retrieve it. Jason, along with the finest that Greek civilization had to offer, set out on the vessel, Argo, and began to take the perilous journey to lands unknown. With the help of a beautiful young sorceress, Medea, he was able to capture the Golden Fleece and bring it back to Greece.

If this had been the end of the story, obviously, all would have lived happily ever after; however, he soon became tired of his wife Medea and found that simple possession of the Golden Fleece and the accomplishment of his life-long goal was a shallow victory. He became a victim of remorse and despair, led a weary and sorrowful life. One day while sitting under the rotting hulk of his great ship, the Argo, a sudden gale detached a beam, causing it to fall upon him and causing instantaneous death.

The saddest part about this classical myth is not that the near-god Jason was killed, because death comes as easily in a myth as it does in the reality of a New York subway. The most tragic part of this story and the one that bears a relationship to many physicians today is that the ultimate dream of a Golden Fleece or "The Golden Sheepskin" does not bring the happiness the individual thought it would. And sadder still is the disillusionment which makes our modern day Jason not only unhappy with his quest and the fulfillment thereof, but he also becomes so cynical that he tells his sons and daughters that the Golden Fleece is not worth their trouble either.

I feel very fortunate personally to still be in a position that, even with all of the hassles and all the threats, medicine still is, to me, the finest calling that this world has to offer. The rewards of caring for one's fellow human being, the smile of a healed child, or the gratitude of a caring family, are and have always been, the Golden Fleece of medicine. My greatest hope for you, dear reader, would be that this is also true for you.

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Hospitals Urged to Complete GHA Medical Ethics Survey

Editor's note: The following article appeared in the August 1990 issue of Georgia Hospitals Today and was authored by Charles H. Keaton, F.A.C.H.E., chairman of the Board of Trustees of the Georgia Hospital Association.

Along with the significant development of state-of-the-art medical technology and scientific breakthroughs that have enhanced our ability to prolong life come some of the greatest medical ethics dilemmas the health care industry has ever faced.

The very definition of "death" is undetermined. Every day health care providers must decide whether to resuscitate patients, or whether to terminate or withhold life support systems. Abortion is and probably always will be an emotional and hotly debated topic.

Cases involving patients with impaired decision-making capabilities continue to spark interest in durable power of attorney laws and living wills, particularly in light of the recent U.S. Supreme Court decision in the Cruzan right-to-die ruling. (The court held that when a permanently unconscious person has left no clear instructions, a state is free to carry out its specified interest in "the protection and preservation of human life" by denying family members' requests to end treatment.)

Hospitals will face these types of situations even more frequently as the terminally ill AIDS population increases. Because of the absence of family members and the declining mental status that often accompanies the progression of AIDS, it is imperative that hospitals initiate advance directives for coping with these patients.

Additionally, organ donation, blood transfusions, research testing and treatment selection are tied closely to informed consent and patient rights. In some instances, these too can be controversial procedures.

The ethical questions raised by the sophisticated level of medical treatment available in the United States are as varied as individual circumstances. They stem as much from religious convictions and deep-rooted personal beliefs as they do from financial and logistical constraints. And there are no pat answers for addressing issues as complicated as the advanced society that created them.

That is why the Georgia Hospital Association has charged a subcommittee of its Chairman's Roundtable with defining the role of hospitals in the medical ethics discussion. How will we, and how should we as an industry answer these questions?

I urge hospitals to help GHA set a course of action that will be mutually beneficial to all of us. Please complete and return the medical ethics survey. If you have misplaced your copy, please contact GHA for another one.

The life-and-death questions being raised today are not going to disappear. Sooner or later every hospital will be expected to make a decision that exceeds the parameters of anything it has previously encountered. With your assistance, a plan for handling ethical dilemmas can be available before that time comes.

AHA Board Maps Strategy to Fill Insurance Gaps

The American Hospital Association Board of Trustees approved a series of recommendations to expand financial support for medically indigent children, during its annual convention in Washington, D.C. July 29-Aug. 1.

The board agreed that Congress should offer special tax incentives to permit low- and moderate-income individuals to purchase affordable private insurance coverage for their children.

The AHA supports legislation that would offer a tax credit for health insurance costs borne by families with incomes up to $18,000. Congress could improve the Medicaid program by establishing a uniform and consistent eligibility standard at 185 percent of the federal poverty level. That figure should be extended to 250 percent of the poverty level for pregnant women and children under age six, through a Medicaid "buy-in," under which enrollees would pay an insurance premium.

About the Artist: **Haidee Becker**

HAIDEE BECKER was born in 1950 in Los Angeles, California, and raised in Rome, Italy, and Vienna, Austria. She moved to London, England, in 1966. She was offered a place at Art School but decided to study under the tuition of a master draughtsperson, Uli Nimptsch, R.A., with whom she studied for 6 years. During this period, she also studied with artists Adrian Ryan and Elizabeth Keys. Ms. Becker then returned to Vienna where she continued her studies with Fritz Wotruba.

Ms. Becker has recently held a highly successful one woman exhibition at the Odette Gilbert Gallery in London's Mayfair. Amongst this exhibition of portraits and still lives are a series of portraits of the artist Stewart Helm, one of which is reproduced on the cover of this *Journal*. "Stewart Series" captures an intense and haunting dialectic between Ms. Becker and her sitter, an element which is apparent throughout her oeuvre.

Neither wholly academic nor absorbed by certain contemporary ideologies prevalent in art, Ms. Becker's work is stylistically pure though rooted in expressionism. Through a powerful use of color, which is always subservient to the demands of form, her portraits of such figures as Ian Charleston, Jean Helion, and Tim Barlow, alongside images of peasant cooks, boxers, friends, and still lives, reveal a startling psychological insight.

This insight has been noted by Britain's Poet Laurate, Ted Hughes. He has written of Becker's work, "When I saw the portraits, the shock of their live presence, in such marvellously fluid and moulded colours, was something I shall never forget. Those pictures became for me an ideal of portraiture. The painted surface like some kind of precious substance — nothing fixed or cold, yet nothing arbitrary or external — and a vibrant immediacy of the person. After that, I got to know some of her still lives and flowers. They have for me the essential quality; the revelation of a passionate inwardness, like portraits of hypnagogic images just about to materialize . . . "

Ms. Becker has held many one woman exhibitions in London. In addition to her recent exhibition in Cork Street at the Odette Gilbert Gallery, she has also exhibited at the New Grafton Gallery, C. D. Soar & Son, her work is also kept by the National Portrait Gallery and is featured in the collections of such notaries as Ted Hughes, Lady Claire Strafford, Hume Cronin, and Jessica Tandy.

She is married to the cellist David Kenedy, and they live in London with their two children.

Haidee Becker is represented in America by Galerie Timothy Tew, TULA D2, 75 Bennett St., Atlanta, GA 30309; 404-352-0655.

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1. Data on file, G.D. Searle & Co. **2.** 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

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Of War And Peace — A Lament

The world is now too dangerous for anything but truth, too small for anything but brotherhood."

REV. A. POWELL DAVIES

"That is why I have attacked the magic before the fear: because the marvel lies below the fear. In the minds of most people today, the fear is plainly uppermost. They are afraid of the future; and if you ask them why, they conveniently blame the atomic bomb. But the atomic bomb is only the scapegoat for our fears. We are not afraid of the future because of a bomb. We are afraid of bombs because we have no faith in the future."

A Sense Of The Future
J. BRONOWSKI

"On a fine November day in 1945, late in the afternoon, I was landed on an airstrip in southern Japan. From there a jeep was to take me over the mountains to join a ship which lay in Nagasaki Harbor. I knew nothing of the country or the distance before us. We drove off; dusk fell; the road and fell away, the pine woods came down to the road, straggled on and opened again. I did not know that we had left the open country until unexpectedly I heard the ship's loudspeakers broadcasting dance music. Then suddenly I was aware that we were already at the center of damage in Nagasaki. The shadows behind me were the skeletons of the Mitsubishi factory buildings, pushed backwards and sideways as if by a giant hand. What I had thought to be broken rocks was a concrete power house with its roof punched in. I could now make out the outline of two crumpled gasometers; there was a cold furnace festooned with service pipes; otherwise nothing but cockeyed telegraph poles and loops of wire in a bare waste of ashes. I had blundered into this desolate landscape as instantly as one might wake among the craters of the moon. The moment of recognition when I realized that I was already in Nagasaki is present to me as I write, as vividly as when I lived it. I see the warm night and the meaningless shapes; I can even remember the tune that was coming from the ship. It was a dance tune which had been popular in 1945, and it was called 'Is You Is Or Is You Ain't Ma Baby?'. These essays, which I have called Science and Human Values, *were born at that moment. For the moment I have recalled was a universal moment; what I met was, almost as abruptly, the experience of mankind. On an evening like that evening, some time in 1945, each of us in his own way learned that his imagination had been dwarfed. We looked up and saw the power of which we had been proud loom over us like the ruins of Nagasaki. The power of science for good and for evil has troubled other minds than ours. We are not here fumbling with a new dilemma; our subject and our fears are as old as the tool making civilizations. Men have been killed with weapons before now: what happened at Nagasaki was only more massive (for 40,000 were killed there by a flash which lasted seconds) and more ironical (for the bomb exploded over the main Christian community in Japan). Nothing happened in 1945 except that we changed the scale of our indifference to man; and conscience, in revenge, for an instant became immediate to us. Before the immediacy fades in a sequence of televised atomic tests, let us acknowledge our subject for what it is: civilization face to face with its own implications. The implications are both the industrial slum which Nagasaki was before it was bombed, and the ashy desolation which the bomb made of the slum. And civilization asks of both ruins, 'Is You Is Or Is You Ain't Ma Baby?'."*

Science and Human Values
J. BRONOWSKI

"For us lads of eighteen, they ought to have been mediators and guides to the world of maturity, the world of work, of duty, of culture, of progress — to the future. We often made fun of them and played jokes on them; but in our

hearts we trusted them. The idea of authority, which they represented, was associated in our minds with a greater insight and a manlier wisdom. But the first death we saw shattered this belief. We had to recognize that our generation was more to be trusted than theirs. They surpassed us only in phrases and in cleverness. The first bombardment showed us our mistake, and under it the world as they had taught it to us broke in pieces. While they continued to write and talk, we saw the wounded and dying. While they taught that duty to one's country is the greatest thing, we already knew that death-throes are stronger. But for all that we were no mutineers, no deserters, no cowards — they were very free with all these expressions. We loved our country as much as they; we went courageously into every action; but also we distinguished the false from the true, we had suddenly learned to see. And we saw that there was nothing of their world left. We were all at once terribly alone; and alone we must see it through.... Night again. We are deadened by the strain — a deadly tension that scrapes along one's spine like a gapped knife. Our legs refuse to move, our hands tremble, our bodies are a thin skin stretched painfully over repressed madness, over an almost irresistible, bursting roar. We have neither flesh nor muscles any longer, we dare not look at one another for fear of some incalculable thing. So we shut our teeth — it will end — it will end — perhaps we will come through. Suddenly the nearer explosions cease. The shelling continues but it has lifted and falls behind us, our trench is free. We seize the handgrenades, pitch them out in front of the dug-out and jump after them. The bombardment has stopped and a heavy barrage now falls behind us. The attack has come. No one would believe that in this howling waste there could still be men; but steel helmets now appear on all sides out of the trench, and fifty yards from us a machine gun is already in position and barking. The wire entanglements are torn to pieces. Yet they offer some obstacle. We see the storm troops coming. Our artillery opens fire. Machine guns rattle, rifles crack. The charge works its way across. Haie and Kropp begin with the handgrenades. They throw as fast as they can, others pass them, the handles with the strings already pulled. Haie throws seventy-five yards, Kropp sixty, it has been measured, the distance is important. The enemy as they run cannot do much before they are within forty yards. We recognize the distorted faces, the smooth helmets: they are French. They have already suffered heavily when they reach the remnants of the barbed wire entanglements. A whole line has gone down before our machine guns; then we have a lot of stoppages and they come nearer. I see one of them, his face upturned, fall into a wire cradle. His body collapses, his hands remain suspended as though he were praying. Then his body drops clean away and only his hands with the stumps of his arms, shot off, now hand in the wire. The moment we are about to retreat three faces rise up from the ground in front of us. Under of the helmets a dark pointed beard and two eyes that are fastened on me. I raise my hand, but I cannot throw into these strange eyes; for one mad moment the whole slaughter whirls like a circus round me, and these two eyes that are alone motionless; then the head rises up, a hand, a movement, and my handgrenade flies through the air and into him. ... And men will not understand us — for the generation that grew up before us, though it has passed these years with us here, already had a home and a calling; now it will return to its old occupations, and the war will be forgotten — and the generation that has grown up after us will be strange to us and push us aside. We will be superfluous even to ourselves, we will grow older, a few will adapt themselves, some others will merely submit, and most will be bewildered; the years will pass by and in the end we shall fall into ruin. But perhaps all this that I think is mere melancholy and dismay, which will fly away as the dust, when I stand once again beneath the poplars and listen to the rustling of their leaves. It cannot be that it has gone, the yearning that made our blood unquiet, the unknown, the perplexing, the oncoming things, the thousand faces of the future, the melodies from dreams and from books, the whispers and divinations of women, it cannot be that this has vanished in bombardment, in despair, in brothels. Here the trees show gay and golden, the berries of the rowan stand red among the leaves, country roads run white out to the skyline, and the canteens hum like beehives with rumours of peace. I stand up. I am very quiet. Let the months and years come, they bring me nothing more, they can bring me nothing more. I am so alone, and so without hope that I can confront them without fear. The life that has borne me through these years is still in my hands

and my eyes. Whether I have subdued it, I know not. But so long as it is there it will seek its own way out, heedless of the will that is within me. He fell in October, 1918, on a day that was so quiet and still on the whole front, that the army report confined itself to the single sentence: All quiet on the Western Front. He had fallen forward and lay on the earth as though sleeping. Turning him over one saw that he could not have suffered long; his face had an expression of calm, as though almost glad the end had come."

All Quiet On The Western Front
ERICH MARIA ROMARQUE

XXXIV

"Here dead lie we because we did not chose
To live and shame the land from which we sprung.
Life, to be sure, is nothing much to lose;
But young men think it is, and we were young."

More Poems

A.E. HOUSMAN

IT IS LATE AUGUST, 1990, and once again the threat of war hangs menacingly over us. It seemed so unlikely a few days, a week or so, ago. The Middle East, the Desert, lay far away. Indeed, so distant as not to pose a danger. And I, long since mustered out of the Great War to end all global conflicts, saw little danger to my peaceful life. But today, in the security of this distance and the peace of my world, my friend, my physician colleague, left the serenity of his urological practice to staff a Navy hospital left bereft of physicians by those now in that Desert. The wife of yet another friend, she a nurse, left yesterday for active duty, leaving physician husband and newborn son alone. And so I thought again of that distance, that quiet, that serenity. I find myself again on the verge of a war.

War had come first into my life on a quiet Sunday afternoon in 1941 when the serenity of the small country town was broken by the news that an unexpected attack upon the U.S. Navy at Pearl Harbor had been carried out by the Japanese Empire. The war in Europe had turned in our favor, and yet here we found ourselves engaged on another front with a formidable adversary. My cousin, little in days beyond his eighteenth year, had at the time been drafted, trained and within 6 weeks sent into the Battle of the Bulge and killed. Little time passed before I too found myself ungainly clad in khaki and greeting Florida coral snakes eye to eye while crawling belly down through the training grounds of Florida palmetto swamps. Such training comes with great effort to the uninitiated. A new language must be learned. "It ain't a 'gun,' " the battle hardened drill sargeant shouted at me. "It's your 'rifle.' Climb that God damned tree. Unzip your pants and grab your organ and then you yell, 'this is my gun and this is my rifle' " With fear and trembling, I climbed. And I yelled. The months went by in a cloudy mist of military acclamation until the Bomb destroyed Hiroshima and then Nagasaki. Soon peace came again. Time now to muster out. The long ride home, and the disrupted life regained. It had ended.

"We . . . seem to stagger out of one conflagration only to gather ourselves together, slowly and with painful effort, to finally regain our courage, our self confidence, our brashness, and then to run chin held high into the battle again. Our memory seems so short."

But had it ended? Our jaded memories fell slowly away, and in their place came Korea and then Vietnam. They, too, passed from us leaving scars of personal loss and from the latter an emotional reaction itself asking, demanding, that we with previously unused vigor examine our commitment, our honest devotion, to "peace." War had been pushed far away from us

and peace wrapped about us as distance lent us security. But yesterday my friend's nurse wife left home, and today the urology friend departs. And so I asked myself if there is a distance, a quietness, a security which will shield us from the horror. We, all of us on this fragile planet, seem to stagger out of one conflagration only to gather ourselves together, slowly and with painful effort, to finally regain our courage, our self confidence, our brashness, and then to rush chin held high into the battle again. Our memory seems so short. The horror, the hopelessness, the devastating destructiveness fades as the sun sets and sleeps in peace while the morning rushes again upon us full of hope. Another chance to assert ourselves. Spread 'democracy,' freedom of speech and our ideals across the land. Fling the blanket of Christianity, of Judaism, of Muslim, about the universe. A Brave New World to conquer. And all the while the subtle whisper of Agincourt, of Verdun, of Gettysburg, of Guadalcanal, of the 38th Parallel, of Saigon eludes our restless spirit. Shall we ever know peace or are we destined to forever, we who now populate this fragile deteriorating sphere, to forever find our peace in a never ending search for our next encounter with each other.

This embattled spirit found peace last in 1945 when the wisdom and technical prowess of the West placed and detonated an atomic device above two Japanese cities. I cried. The war which I had been trained, conditioned, programmed for had ended. What was I to do now? The enemy had disappeared. My skills were no longer needed. I could go home. No more to plunder the land of those who threatened me. I found myself devastated.

I look back in time as we stand on the threshold of yet another conflict and marvel at that 18 year old who seems so foreign, so misunderstood, to me now. I think. "I hardly knew thee." The marvelous and unbridled hatred which had been so carefully nurtured in him, the desire to destroy the despised enemy regardless of any personal qualities, seem to me now the characteristics of someone I knew not. Oh, surely I now understood the insanity of a crazed leader and the mandate to control him. Certainly the need to protect, to keep secure, one's homeland was clear. More clear than these however the soldier grown to manhood looked ever more deeply for a way, a plan, a negotiation leading us all to peace. No doubt such thoughts had run through the minds of many peoples through the ages. Last and most seriously perhaps was Woodrow Wilson after the first great World War. He talked then of a League of Nations. The United Nations, fragile and staggering, yet learning to walk and surely impotent, yet represented an attempt at such a consensus. One could only think that we seem to be rushing over faster to that point where "the world is too dangerous for anything but truth, too small for anything but brotherhood."

CRU

A Brief Personal War Bibliography

All Quiet On the Western Front, Erich Maria Remarque
Men At War, Ernest Hemingway
Hiroshima, John Hersey
Back Home, Bill Mauldin
Up Front, Bill Mauldin
Hiroshima Diary, Michihiko Hachiya, M.D.

RED HILLS

I live among red hills
Which Autumn rains have bled,
Once green-clad, pine-spread hills
Before the pines were dead.

The paradox of building
The city and the town:
The valleys get the gilding,
The hills the tearing down.—

For locust-man, in driving
To meet his own demands,
Consumes the pines in striving
To automate the lands,

Forever letting learning
Weigh down ideals with wings,
To keep his eyes returning
To lower-valleyed things!

MOUNTAIN IN AUTUMN

The cup of night spills on the western rim
As Summer drinks a final toast to Fall.
Golden droplets splash her verdant shawl
As Autumn fills the glass up to its brim.
Before the stars have set there will be spinning
Varicolored scenes before his eyes,
Begging brilliance from the fresh sunrise
To keep a crispness caught at their beginning.
How gaunt the mountain looks, yet how gay
She dressed to receive her Autumn lover,
Swirling skirts of red and gold! Above her
Clouds may gather, making night of day,—
But Autumn gives more reason to be glad
Than all the lesser beauties Summer had!

JOHN RANSOM LEWIS, M.D.

Dr. Lewis, a plastic surgeon in Atlanta, is Georgia's Poet Laureate.

CALENDAR

OCTOBER

4-5 — *Amelia Island, FL*: **Third Annual Conference on Critical Care.** Category 1 credit and AAFP Prescribed credits. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

4-5 — *Atlanta*: **Women's Health Care: A Continuing Challenge**. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5 — *Augusta:* **Pain Management in the Primary Care Setting**. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

5 — *Atlanta:* **Current Management of Low Back Pain.** Contact CME Office, Abbott Northwestern Hospital, 800 E. 28th St., Minneapolis, MN 55407. PH: 612/863-5461.

5-6 — *Amelia Island, FL:* **Third Annual Symposium on Critical Care.** Category 1 credit. Contact Penny Ballard, Office of CME, Medical Center of Central GA., 777 Hemlock, Box 1005, Macon 31208. PH: 921/744-1634.

7-12 — *Atlanta:* **37th Annual Meeting, Am. Coll. of Angiology.** Contact Am. Coll. of Angiology, 1044 Northern Blvd, Ste. 103, Roslyn, NY 11576. PH: 516/484-6880.

6-7 — *Atlanta:* **Georgia Gastroenterologic and Endoscopic Society**. Contact Nancy Graham, 609 15th St., Augusta, GA 30901. PH: 404/724-2078.

11-14 — *Sea Island:* **Georgia Orthopaedic Society**. Category 1 credit. Contact Nell Hurt, 105 Collier Road, Ste. 5000, Atlanta 30309. PH: 404/355-0743.

12-14 — *Atlanta:* **Gastroenterology For Primary Care Physicians.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

13 — *Atlanta:* **Plastic Techniques in Suturing.** ACEP Category 1 and AAFP Prescribed Credit. Contact Plastic Techniques in Suturing, P.O. Box 62682, 141 Business Park Dr., Virginia Beach, VA 23462. PH: 804/473-2443.

18-19 — *Atlanta:* **Neurotrauma Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

18-19 — *Atlanta:* **Surgical Management of Complex Continence Problems.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1400 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-23 — *Atlanta*: **Quantitative Thallium Myocardial Tomography.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-27 — *Atlanta*: **Bladder Cancer Seminar.** Contact Am. Urological Assn., Office of Educ., 6750 W, Loop S., Ste 900, Bellaire, TX 77401. PH: 713/665-7500.

26 — *Atlanta*: **The HIV Positive Patient: Medical and Psychosocial Aspects.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-27 — *Atlanta*: **Advanced Vitreoretinal Surgery**. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

27-28 — *Atlanta*: **Review Course in Hand Surgery.** Contact Am. Soc. for Surg. of the Hand, 3025 S. Parker Rd., Ste. 65, Aurora, CO 80014. PH: 303/755-4588.

28-1 Nov. — *Atlanta*: **American Academy of Ophthalmology**. Category 1 credit. Contact AAO, 655 Beach Street, Box 7424, San Francisco, CA 94120-7424. PH: 415/561-8500.

28-2 Nov. — *Atlanta*: **Magnetic Resonance Imaging**. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

NOVEMBER

2-3 — *Atlanta*: **Third International Workshop on Laser Surgery of the Cornea**. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

2-4 — *Atlanta*: **Georgia Chapter of the American Academy of Pediatrics.** Category 1 credit. Contact William Mankin, 4059 Land O'Lakes Drive, NE, Atlanta 30342. PH: 404/237-3922.

8-10 — *Atlanta*: **Georgia Academy of Family Physicians**. AMA Category 1 credits and AAFP Prescribed credits. Contact Judy Rayburn, Dir. of Education, GAFP, 3760 LaVista Rd., Ste 100, Tucker 30084. PH: 404/321-7445 or 800/392-3841.

12-13 — *Helen*: **27th Annual Psychiatric Institute on Group Behavior and Group Leadership.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-17 — *Atlanta*: **Review Course in Addiction Medicine**. Contact Am. Soc. of Addiction Medicine, 12 W. 21st St., New York, NY 10010. PH: 212/206-6770.

16-18 — *Atlanta*: **MAG Scientific Assembly**. Category 1 credit. Programs in: Allergy, Cardiology, Depression, Emergency Medicine, Internal Medicine, Neurology, Neurosurgery, Obstetrics/Gynecology, Occupational Medicine, Ophthalmology, Orthopedics, Otolaryngology, Pathology, Plastic Surgery, Psychiatry, Contact MAG, 938 Peachtree Street, NE, Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

CODE BLUE: Adolescent Health, The Crisis and The Hope

Gary Bawtinhimer, M.D.

It is important that all physicians begin to accept responsibility for identifying and evaluating mental health and behavioral problems that may affect adolescents.

WE HAVE KNOWN for quite some time that the state of adolescent health in America is in serious jeopardy. However, until recently, the extent and ramifications of the problem have not been so clearly defined as they have been in the recently published report entitled, "Code Blue: Uniting for Healthier Youth." This paper was a project of the National Commission on the Role of the School and the Community in Improving Adolescent Health sponsored by the Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, and the Centers for Disease Control. (Copies can be obtained by writing NASBE 1012 Cameron Street, Alexandria, VA 22314 or call 703-684-4000.) This national commission was composed of prestigious leaders in both education and medicine from across the United States. Their findings show a clearly alarming picture of the physical and mental health of adolescents in America today.

Startling statistics in the "Code Blue" report include the following:

- 10% of boys and 18% of girls make at least one suicide attempt during adolescence.
- Each day in America, 135,000 students bring firearms to school.
- Homicide remains the leading cause of death for 15-19 year old blacks.
- More than 1,000,000 adolescent females become pregnant each year.
- 39% of high school seniors become heavily intoxicated with alcohol within a 2-week period.
- 3.5 million adolescents have tried marijuana with one-third being regular users.

Some very worrisome trends include the following:

- Between 1950-1985, there has been a 30-fold increase in the rate at which adolescents get arrested.
- Teenage pregnancy rates have doubled during the past 20 years.
- Twice as many children and adolescents are in families going through a divorce now in contrast to that in 1960.
- In 1950, 5% of youth experimented with illegal drugs in contrast to 30% in 1987.

Dr. Bawtinhimer specializes in adolescent psychiatry. He is the Medical Director of Inner Harbour Hospitals, not-for-profit extended care facilities for troubled children and teenagers. Send reprint requests to him at 4685 Dorsett Shoals, Rd., Douglasville, GA 30135.

- In 1969, approximately 13.5 percent of children/adolescents lived in poverty; by 1989, that number had almost doubled.

These statistics clearly point out the dire state of adolescent mental health and its obvious impact on physical health for millions of teenage Americans. Many have described this as the "lost generation." The ramifications of such pervasive illness within a major segment of our population are quite obvious. The Commission for the "Code Blue" Report correctly identified its impact in terms of lost productivity in a generation that may be unable to support its elders during the early part of the next century.

The Role of the Physician In Addressing Adolescent Health Issues

Physicians have long been involved in the medical care of the adolescent patient. Services provided have tended to be fragmented and relegated to certain specialty groups. Primary care physicians, pediatricians, and the more underrepresented specialties of adolescent medicine and adolescent psychiatry have attempted to deal with health issues of youth for quite some time. However, the scope of the problem is of such magnitude that the medical profession can no longer relegate adolescent health care to just those clinicians. Just as the causes for the state of adolescent health are many, the approach to correcting the problem is similarly complex and involves not only the health care profession but also the educational profession, as well as specialized services within the community itself. Americans will have to acknowledge the crisis of adolescent health and prioritize treatment of our children and youth if we are to build a strong and healthy next generation. Georgia physicians can contribute immensely to this effort by taking a direct role in the assessment and treatment of troubled youth.

Different clinicians will have different comfort levels for types of adolescent problems they feel confident to handle. Being able and willing to quickly refer a patient becomes an important tool in the overall quality treatment of adolescent health needs.

What To Do As a Georgia Physician

There are many important tasks that all physicians can perform in evaluating the status of health in the adolescent patients they treat directly or know indirectly through treatment of other family members. It is important that *all* physicians begin to accept responsibility for identifying and evaluating mental health and behavioral problems that may affect adolescents. With some minor changes in approach and style, physicians can become comfortable in talking with teenagers and identify major risk areas. It behooves us all to take a few moments when talking with teenagers (or their parents) to inquire about the health, lifestyles, and behaviors of these youths. To facilitate this evaluation, I have developed the acronym "T-E-E-N-S." Georgia physicians are encouraged to follow this simple step-by-step procedure which, done collectively, could have a major impact upon the identification of major risk factors in teenagers and thereby facilitate the early implementation of both disease prevention and treatment measures.

T—Talk

The first and perhaps most difficult challenge to physicians not familiar with working with adolescents will be to become comfortable talking with these youths. Many adults (and physicians are no exception) feel awkward at times and unable to communicate with teenagers. While teenagers may have their own "lingo," they nontheless have some of the basic needs which we all have. Primarily, teenagers want to be understood, respected, and empowered with as much responsibility as they are able to handle successfully. Taking a few undistracted minutes to talk to teenagers helps them feel special and important. The adult is then viewed as an influential authority figure who is concerned about them. If teenagers feel that you are taking them seriously, they in turn will take you seriously. Speak in very basic terms and avoid using professional jargon when speaking with adolescents. Ask simple questions such as "How are things going?," "Are you happy with the way your life is going now?," "How are things in your family and at school?" By and large, once teenagers feel you are not a direct threat to their autonomy and have their best interests at heart, they will quickly share with you very personal information about how things actually are going for them.

E — Evaluate

Besides general medical questions as to their physical health, there are basically seven areas that can quickly be evaluated in adolescents. These areas focus on behaviors and relationships that might

indicate serious health problems or risks of mental or physical illness. First, ask the teenager how school is progressing. Performance in school, particularly if there is a sudden change, is usually one of the earliest indications of a teenager in trouble. If grades remain steady and the adolescent seems interested and engaged in the educational process, then there is usually less chance of a serious problem in that teenager's life. On the other hand, if there has been a precipitous decline in academic performance, loss of interest, or lack of attendance at school, a "red flag" is raised that other very serious and potentially health endangering behaviors or illnesses are possibly occurring.

Then ask the teenager about his or her driving. In general, teenagers view driving as very important. Getting behind the wheel symbolizes autonomy, independence and power for the teenager. Unfortunately, automobiles claim more adolescent lives than any disease or other activity. As such, inquire as to whether the teen has received any traffic violations (particularly excessive speed), or has been in any accidents. A teenager who has had multiple tickets or collisions is indirectly signaling us that he or she is having serious problems. Finding the root of these problems and taking corrective actions could save that teenager's life or the lives of others.

Next, inquire about the patient's family and friends. Ask how his or her relationships are going and note if there seems to be any real serious conflict between the adolescent and a particular family member. The response, "I don't want to talk about that!" usually indicates turmoil and family strife. Ask about the young person's friends and associates. Is their peer group active in school and community, or does the teenager prefer to identify with those who use drugs, are in trouble with the law, or are into the "occult"?

It is very important then to inquire directly about that teenager's use of alcohol and any illegal drugs. Generally, if teenagers sense that you have their best interests in mind, and are not moralizing or condescending, they will discuss with you what substances they are using or have tried. Note particularly the variety, extent, and frequency of drug use. Ask if the use of these mind-altering substances has interfered with their relationships with peers or family, or with school functioning. Ask if they have been using hallucinogens, including marijuana or LSD. Also ask if they have tried cocaine or crack, inhalants, or had any IV drug use.

Next, ask the teenager about whether he or she has been sexually active. My experience is that if the clinician is very direct and comfortable in asking the teenager about sexual activity, the youth in turn will be quite open and specific. Inquire as to whether the teenager is having unprotected sex. Also ask if there have been multiple sex partners. Ask if the teenager has heard about AIDS and if this is of concern.

I also inquire of teenagers if they have had any *legal* problems or arrests. Again, if this is approached in a straightforward manner, if you show concern and are not judgmental, teenagers generally will confide in you.

An extremely important area of concern is that of suicide. The rate of suicide in this age group has increased dramatically in the past 30 years. Suicide is the second leading cause of death for this age group. Be direct but empathic when you ask the teenager if he or she has ever felt suicidal. A question formed this way is usually well accepted by the teen: "Sometimes life can seem very frustrating and make you depressed. Have you ever gotten to the point where you felt life was not worth living?" Any affirmative answer should be taken seriously. Obtain specifics about current suicidal thoughts or plans and any past attempts. Be prepared to refer to an adolescent psychiatrist promptly.

The statistics published in the "Code Blue" report clearly point out the dire state of adolescent mental health and its obvious impact on physical health for millions of teenage Americans.

E — Educate

In terms of health maintenance and disease prevention, patient education is a vital need. Schools are doing a better job these days in educating young people about the dangers of drugs and sexually transmitted diseases. However, the physician can play a vital role in filling in gaps in teenagers' education. Be certain that your patients understand the risk of AIDS, particularly through having multiple partners and/or unprotected sex. Do not expect celibacy in this age group. The statistics show it is just not so. Also, be sure teenagers understand the medical seriousness of using illegal drugs, particularly the more dangerous crack cocaine, powerful hallucinogens, and intravenous drugs. Next, it is important to talk with teens about nutrition and exercise. Make sure adolescents have a good understanding of a balanced diet and the importance of regular exercise in maintaining health.

N — Notify

After having talked with and evaluated the adolescent, and offering what education seems appropriate, the physician is then in a position to make a critical decision as to whether or not there are serious risk factors, dangerous behaviors, or indications of illness such that it is necessary to notify others. Specifi-

cally, you will need to decide if the teenager's parents or guardians should be contacted when the youth's health is in clear jeopardy. This is typically an area in which many clinicians are very uncomfortable, as it involves patient confidentiality. In my opinion, if the teenager has indicated that he or she is heavily involved in dangerous drugs, driving recklessly, having unsafe sex, or is suicidal, then the patient's best interest is served by notifying the parent or guardian. In so doing, adequate intervention (and prevention) can be undertaken. If that teenager already is in treatment with a mental health professional, it is good clinical practice to call his or her counselor and make sure the counselor is aware of the teenager's problems that you have identified. On the other hand, if the teenager seems to be practicing good health maintenance and disease prevention, I would also inform the parents that the teenager (and the parents) are doing a good job. We all need to re-enforce good health practices just as often as we identify disease-promoting behaviors.

S — Send

The vast majority of physicians do not specialize in treating the medical and/or mental health needs of adolescents. As such, it becomes extremely important that all physicians who come in contact with teenagers have a network of referral sources that they can access when needed. For the acutely emotionally ill adolescent, one who evidences dangerous behaviors or may be suicidal, time is of the essence. Sending that patient for professional counseling may be life-saving. As such, every physician should know one or more adolescent psychiatrists and adolescent medicine specialists with whom he or she can consult. Different clinicians will have different comfort levels for types of adolescent problems they feel confident to handle. Being able and willing to quickly refer a patient becomes an important tool in the overall quality treatment of adolescent health needs.

As Georgia physicians become more comfortable and actively involved in talking with and evaluating teenagers, we will certainly be able to improve their access to health care. Physicians can be influential spokespersons for improving adolescent health. With the progressive deterioration of the nuclear family during the last 3 decades, the responsibility for identifying teenagers at risk and intervening early in order to reduce morbidity and mortality is becoming more the domain of the physicians, educators, and the police. Unfortunately, there is no time to wait to see if the state of the family changes. All physicians must now be more acutely aware of the needs of teenagers and willing to intervene early and decisively.

The Experience of a Child and Adolescent Inpatient Unit in London

N.D. Feibelman, M.D., Bryan Lask, M.D., R. Alan Williams, Ph.D.

Abstract

THE MILDRED CREAK Unit of the Hospital for Sick Children, Great Ormond Street, London, England, has been evaluating and treating children and adolescents now for over 16 years. A portion of their valuable experience, with 394 patients reviewed, is presented in this article. Items discussed include: (1) major diagnostic labels utilized and their frequency of use; (2) ages and sex of young people within the major diagnostic categories; and (3) information on discharge status plus average length of stay. This paper affords the reader an opportunity to compare the Mildred Creak Unit experience with his or her own experience, hopefully enhancing further international sharing of child and adolescent data.

Introduction

BY EXAMINING comparative patient-related data, clinicians may be sensitized to various cultural and social influences affecting psychiatric practice. Looking at demographic data and course of treatment highlights the social as well as purely pathognomonic factors determining our approach to patient identification and care.

Interest in this topic developed when the senior author observed first-hand the evaluation and treatment activity on a tertiary care child and adolescent psychiatric inpatient unit in Great Britain. This report describes a portion of the history and experiences of the Mildred Creak Unit for Child and Adolescent Psychiatry at the Hospital for Sick Children, Great Ormond Street, London.

Setting

The Mildred Creak Unit (MCU) was opened in October of 1971 and had treated 394 patients by September, 1986. The MCU is a 10-bed tertiary care child and adolescent psychiatric unit which serves also as a teaching hospital. The age of children admitted generally ranged between 7 and 17 years. Younger children were occasionally accepted, but for shorter, limited periods of time and only with increased parental involvement. Children were referred from a number of sources to include pediatric wards/clinics, general practitioners, families, etc.

The unit is family-oriented, though most children additionally received individual therapies of various types (e.g., cognitive-behavioral, pharmacotherapy, etc.). Close work with the family enabled nursing staff to work directly with important parent-child management issues and allowed for strong links to be maintained between the child and the family. The children followed a structured therapeutic program individualized to their needs.

Treatment was conducted by an interdisciplinary team which consisted of the Consultant (Child and Adolescent Psychiatrist), the Senior Registrar (Child and Adolescent Psychiatrist, Senior level Fellow), Child Psychotherapist, Psychiatric Social Worker, Clinical Psychologist, Teacher, Nursing Staff, Physical Therapist, Dietician, and other ancillary health personnel.

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Table 1 — Patients Treated at Mildred Creak Unit, London, England, by Diagnosis, Sex, Age, and Length of Stay, 1971-1986

Diagnoses	*Total Cases*	*% Males*	*Age Range*	*Average Male Age*	*Average Female Age*	*% Discharged to Other Than Original Source*	*Average Length Stay (days)*
Eating Disorders	64	23	5-17	12.0	11.8	20	108
Encopresis	39	64	5-13	9.9	8.4	18	90
Depression	39	46	7-14	11.3	10.9	24	86
Conduct Disorder	32	88	7-13	9.2	10.0	31	106
Epilepsy	28	60	5-14	10.4	10.8	25	56
Psychosis	28	57	5-13	10.3	10.2	44	161
Somatoform Disorder	27	52	5-14	11.0	10.5	11	92
Behavior Disorder	24	75	5-13	8.9	7.0	21	61
ADD/H	19	79	3-10	7.5	5.7	22	64
School Phobia	18	72	10-13	11.6	11.2	5.6	96
Autism/PDD	18	78	3-12	8.2	7.5	11.1	39
Anxiety/Panic DO	16	94	10-15	12.6	11	25	105
Retardation (IQ 70)	8	50	3-8	4.2	6.2	12.5	33
Tic/Tourette's DO	5	67	8-14	10.3	10.5	0	54
Enuresis	4	100	10-13	11.7	NA	20	114
Asthma	4	75	10-13	11.6	10.0	25	45
Sex Abuse Adjustment Disorder	3	67	5-12	9.5	5.0	67	111
*Other Disorders	18						
Total	394	60	2.5-17	9.3	9.1	20	90

*Other Disorders include: Elective Mutism (2), Tantrum (3), Asperger's Syndrome (2), Obesity (2), Brain Tumors (2), No diagnosis (7).

Methods

Patient records were reviewed to obtain the following data: primary diagnosis, age and sex of the patient, disposition of the patient following discharge, and length of stay.

Diagnoses and other data were obtained by several routes. The main source of information was a log book maintained on the Unit. This was supported by interviews of the attending staff, plus patient chart reviews. All of these sources were used to develop the information presented in this paper. The diagnostic categories used by attendings in London may be found in either the DSM III, DSM III-R, or the ICD-9.[1-3]

Results

The data obtained from 394 patient records are presented in Table 1. The following indices are depicted for patients in each diagnostic category:

1. The total number of cases per diagnostic category
2. Percent of males (also giving one the percentage of females) per diagnostic category
3. The age range per diagnostic category
4. The average age of male patients for each diagnostic category
5. The average age of female patients for each diagnostic category
6. The percentage of patients discharged or transferred to placements other than the original home or source of referral (e.g., patients transferred to speciality units or to extended care facilities because of the extreme severity of their illness)
7. The average lenth of stay for each diagnostic category

Totals for each of the data indices are also shown.

Discussion

The largest total number of cases involved patients with eating disorders, and the majority of these were diagnosed with anorexia nervosa. This is the only diagnostic category other than depression for which males are in the minority.

Reviewing the number of cases admitted yearly revealed that the number of eating disorder cases increased markedly in 1984, 1985, and 1986. This increase, however, appeared to represent, in part, the changing clinical interests of the staff.

In comparing these data to those obtained in the United States, one is impressed with the relatively high percentage of males and also with the younger age of admission for these patients.

Encopresis was the second most frequently assisgned primary diagnosis. This rate of encopretic diagnosis likely exceeds that on most similar psychiatric units in the United States.

Depression, the only other diagnosis that was female dominated, is ranked third. As one looks at the number of cases with this diagnosis admitted each year, there is a decrease found occurring since 1983. The exact cause for this decline is not known.

As one might expect, conduct disorder is high on the list with an age range from 7 to 13 years, with a definite predominance of males. In general, males are concentrated in the aggressive, extroverted diagnostic categories, for example, conduct disorders, behavior disorders, and attention deficit hyperactivity disorders.

Amazingly high on the list are patients with seizure disorders. The majority of these young people had temporal lobe epilepsy (TLE) (psychomotor seizures), a few had generalized seizures (grand mal type), and several had focal seizures. Also present in this group are young people with a mixed type of seizure disorder i.e., temporal lobe epilepsy giving rise to generalized seizures.

Patients with diagnoses of psychosis, psychotic episode, or schizophrenia are noted to have the longest average length of stay.

The unit has experienced a steady flow of young people with physical complaints without an identifiable organic etiology. For this particular group, the conclusion was that of psychosomatic illness. In this category, males and females in equal numbers shared problems of somatization disorders, conversion disorders (hysterical neurosis, conversion type), psychogenic pain disorders, and hypochondriasis. The problem most often quoted in chart review in this group was "hysterical paralysis."

What is meant by the diagnostic group "behavior disorder"? This is a diagnostic group one would like to avoid, as the term is so vague. It continues to appear and reappear, however, especially in chart reviews. This group includes patients with oppositional behavior and those with behavior somewhere between oppositional and full blown conduct disorder. Also in this group are young people with behavior that is difficult to classify, i.e., frequently changing behavior patterns and/or identity disorders.

The largest total number of cases involved patients with eating disorders, and the majority of these were diagnosed with anorexia nervosa.

Attention deficit disorder (ADD) with or without hyperactivity occurs in a younger group in general and is represented mostly by males. The females in this group are on an average nearly 2 years younger than the males. Compared to the experience of most United States treatment centers, ADD in this study is ranked low in prevalence at number nine.

Prendergast suggests that the rates of hyperactivity do not differ significantly between the United States and Europe. In the ICD-9 the diagnosis Conduct Disorder is more inclusive and is more likely to be used than the diagnosis of Hyperkinetic Syndrome.[3-5]

Over-anxious disorders of childhood include 12 patients with obsessions, compulsions, or both, and four patients who experienced excessive anxiety with or without panic attacks. This group is most remarkable in its sex bias — 15 males to 1 female (the one female with obsessions).

The Mildren Creak Unit is a 10-bed tertiary care child and adolescent psychiatric unit in London which also serves as a teaching hospital. Their patients followed structured therapeutic programs individualized to their needs.

Enuresis was noted in other diagnostic groups but not listed in charts as a primary diagnosis. Compared to other groups, this one had a relatively long duration of stay in the hospital — 114 days.

Asthmatics were admitted to the unit especially as psychiatric (emotional) stressors appeared to precipitate bouts of asthma. Also, the severity of asthmatic attacks appeared to be influenced by psychiatric factors. Asthma as a primary psychiatric diagnosis is an interesting concept.

A very small number of patients were admitted with sexual abuse as their major diagnosis. In reviewing the charts in this study, many more cases were found where staff suspected sexual and/or physical abuse but the patient's major problem, for example, was considered that of behavior disorder, conduct disorder, or depression. These cases are therefore listed under behavior disorders, etc.

Asperger's syndrome is a diagnosis that may not be encountered or considered in the United States. This pattern of abnormal behavior was originally described by the Austrian psychiatrist, Hans Asperger and whereas Kanner's work on infantile autism is widely known, Asperger's contribution is considerably less familiar, especially outside the German literature.[6]

Conclusion

A total of 394 cases were studied and placed in one of 18 groups based on the major diagnosis determined for each case. Of these 394 cases, 60% were males, and 40% were females.

The average length of stay for all cases was approximately 3 months. The longest and shortest length of stay were one diagnostic category, Depressive Disorder — shortest, 1 day, and longest, 494 days.

In general, the length of stay on this unit is longer than in the United States but one can readily see that length-of-say data may easily be misconstrued, as the heterogeneity of psychiatric case mix clouds the picture of LOS.[7-10]

The age range of these 394 admissions to the Mildred Creak Unit was 2.5 to 17 years. Not only are there a variety of ages represented but also a variety of cultures to include Anglo-Saxons (English, Irish, and Scottish), Asians (Far East), Indians, Israeli (Middle East), Africans, etc.

An opportunity to review data to include age, sex, diagnosis, etc. on 394 young people receiving care on an in-patient unit over a 16-year period in London, England, has been presented, setting the stage for comparison by others. The ultimate conclusions are those of the readers as they compare the data presented to their own experience. The challenge here is for others to communicate their observations in the hospitals and on the wards in which they work.

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The Legacy of James Edgar Paullin, M.D.

John D. Cantwell, M.D.

HE TRAINED under Sir William Osler, during the "Golden Era" at Johns Hopkins. His reputation was such that he served as president of both the American Medical Association and the American College of Physicians, and was summoned to the bedside of a dying president.

Early Years

James Edgar Paullin (Figure 1) was born in 1881, in Ft. Gaines, Georgia. He attended Mercer University, where he was a classmate of U.S. Senator Walter F. George. A chemistry professor at Mercer, Dr. James F. Sellers, kindled his interest in science, in lieu of the classics and a possible career in the clergy. Paullin did a year of graduate work in science at Mercer and then moved on to medical school at Johns Hopkins, graduating in 1905. He was greatly influenced by Osler. According to an AMA resolution: ". . .the aims and ambitions of his great teacher were emulated throughout his professional career."

His early medical research interests were many, ranging from testing rabies serum and medications for diabetes to presentations on hookworm, typhus, and syphilis. He was the first Atlanta physician to prescribe insulin.

Dr. Paullin served an internship as resident pathologist at Rhode Island Hospital and then returned to Atlanta to do another year of postgraduate work at Piedmont Hospital. From 1906-1911, he served as pathologist for the Georgia State Board of Health and also as professor of pathology at the Atlanta College of Physicians and Surgeons (which became Emory University Medical School in 1915). In 1909, he started clinical work as associate visiting physician at Grady Memorial Hospital, and in 1915 was appointed Professor of Clinical Medicine at Emory.

His early medical research interests were many, ranging from testing rabies serum and medications for diabetes to presentations on hookworm, typhus, and syphilis. He was the first Atlanta physician to prescribe insulin. In World War I, he was apparently "not robust enough" to go abroad with the Emory Unit, but did serve as a major in the Army Medical Corp.

A Thriving Career — And Leadership Role

After the war, Dr. Paullin's medical career began to thrive. He built a large practice and was much in demand as a medical consultant. According to Dr. R. Hugh Wood, Dr. Paullin had learned from Osler the

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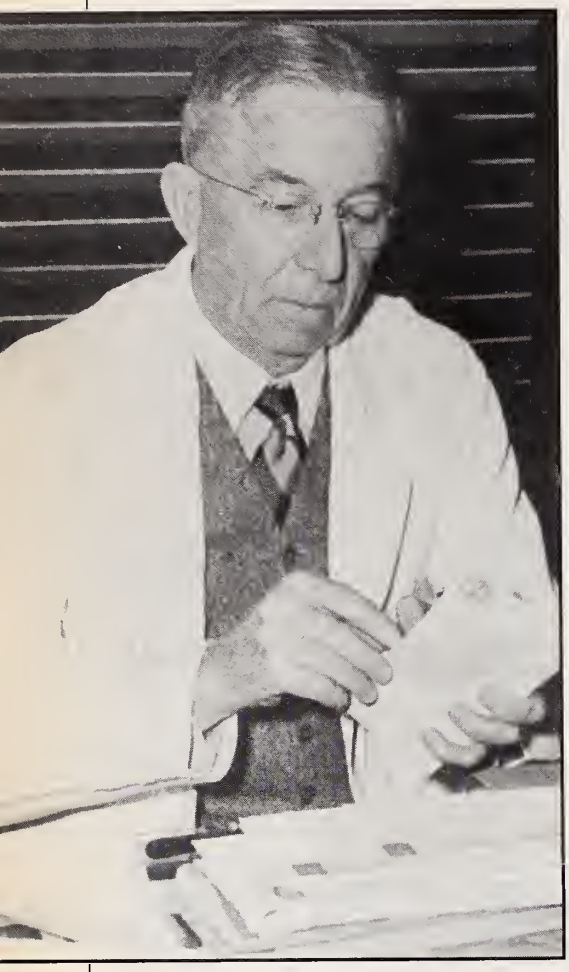

Figure 1 — James Edgar Paullin, M.D.

four-lettered symbol for success, W-O-R-K: "Despising mediocrity, he was never satisfied with less than excellence, and though he demanded much of himself and others, he maintained warm personal relationships."

His activity in medical politics began as President of the Fulton County Medical Society in 1915, and of the Medical Association of Georgia in 1935. He became the only physician to serve as president of both the American College of Physicians (1942) and the American Medical Association (1943-44). He was also one of the first physicians from this area to be invited as a member of the Association of American Physicians.

In 1935, he sponsored the organization of the Southeastern Clinical Club, composed of internists from Atlanta, Birmingham, Nashville, and New Orleans. I recently became a member of that group, which remains very active 55 years later. Dr. Paullin also sponsored a Study Club of young physicians in Atlanta, who met frequently in his home and " . . . absorbed the art of medicine and fellowship from the master." This organization developed into the Atlanta Clinical Society, which continues to meet for dinner, fellowship, and scientific exchange on a monthly basis.

In 1935, he sponsored the organization of the Southeastern Clinical Club, composed of internists from Atlanta, Birmingham, Nashville, and New Orleans . . . and also the Atlanta Clinical Society.

A Testimonial Dinner

A testimonial dinner in his honor, sponsored by the Fulton County Medical Society, was held at the Piedmont Driving Club in July, 1942, with Dr. F. Phinizy Calhoun as toastmaster. Dr. R.H. Oppenheimer, Dean of Emory University Medical School, made the following comments on Dr. Paullin's qualifications as a great teacher:

"First of these is a ready fund of knowledge. By this I mean that Dr. Paullin has been interested in medicine of the past, in the new things in medicine which have come to us in the present, and in the vision of things which are to come in the future. If you should call upon him in the evening you would undoubtedly find him in his library unless, perchance, in latter years he might be spending a few moments at play with his grandchildren. Dr. Paullin's library is filled with medical books and journals, the study of which provide his evening's entertainment after a long day of work. His reading is never casual. Instead, it is done with a critical mind, which enables him to add to his knowledge those things which he feels worthwhile. By thus maintaining a constantly renewed fund of knowledge, he is able to meet students with a vigorous, interested, and stimulating mind.

In a similar manner, he is a keen observer. He studies the symptoms, signs, and other evidences of disease presented by patients with the same critical and analytical attitude he uses in his study of medical literature, arriving at thoughtful conclusions which are free from preconceived ideas and hunches. His work thus stimulates students to the development of an accurate approach to the problem of the patient and its solution.

Dr. Paullin has other valuable qualities. He is interested in the medical school as a whole, in its faculty and in its facilities for the education of students. He has taken an active part in planning and promoting its development in order to make it possible for of all of us to do better teaching. His interest in the students does not cease with their graduation. He is concerned with their development as interns and residents and eventually as practicing doctors.

Finally, Dr. Paullin is interested in the conditions under which doctors are to practice. He is aware of the economic and social changes which will affect the place and work of the doctor in the community."

Dr. Paullin's response reflected his own modesty and great respect for his profession:

"I fully appreciate the fact that you are here tonight, not because

Figure 2 — (L to R) England's Prime Minister, Winston S. Churchill, U.S. President Franklin D. Roosevelt, and Soviet Premier Joseph Stalin at the Yalta Conference in 1945 (Photo by UPI).

of me, but because you wish to recognize and to honor something which is much greater and much higher than any man either living or dead. You are here to pay tribute to a profession which our forefathers founded and whose traditions you and I are attempting to carry forward and we hope that those who follow after us will uphold. We, along with a large group of our citizens, are still interested in demanding for all peoples Life, Liberty, and Freedom. You are here honoring a principle for which the medical profession has always stood for these hundreds and hundreds of years."

World War II And Early Aftermath

During World War II, he served as special consultant to the Surgeon General of the U.S. Navy. He helped organize the Finlay Institute of the Americas and for this work was decorated by Cuban President Batista in 1942. The award was given "because of your distinguished career in your chosen profession; because of your contributions to its development through ministry to the sick, through research, and through teaching; because of your statesmanlike guidance of its organized membership in a time of national crisis; because of the honor you have brought to Georgia, to Atlanta, and to Emory through your notable gifts of mind and heart and of professional skill." In 1944, the Atlanta Chamber of Commerce cited him for "distinguished achievement."

Immediately after the war he was asked to study the medical care of natives in the Pacific Islands and promptly set off on a 25,000 mile-trip. He met with Admiral Chester Nimitz, aboard the historic battleship, *Missouri*, and found him to be "one of the nicest, kindest persons I've ever met," one who was intensely interested in medicine and well informed on tropical diseases. Paullin advised the establishment of extensive facilities for the medical care and education of the Pacific natives, who needed to be weaned from witch doctor rituals. He also advised that " . . . to keep our position in world affairs we must stay in the Pacific."

Dr. Paullin remained an honorary consultant to the Navy Bureau of Medicine and Surgery. In 1947, he was awarded the Presidential Medal of Merit, the highest award a nonmilitary person can receive. Other recipients included Irving Berlin, Henry Ford, Dr. Enrico Fermi, Francis Cardinal Spellman, and Dr. J. Robert Oppenheimer. In 1948, he was one of 10 authorities who presided at the First International Polio Conference in New York.

Consultant To President Roosevelt

Dr. Paullin was best known to the lay public as one of President Roosevelt's physicians. He had been asked by White House physician, Dr. Ross McIntire, to consult on the

President during prior episodes of bronchitis and sinusitis. His advice was also sought as to whether or not the President should run for reelection to a fourth term. In rendering his opinion, Dr. Paullin used a comparison for Roosevelt between the human body and an automobile:

"Let's assume that you're setting out on a 10,000 mile trip — (in) a brand new machine. Hitting on every cylinder, you burn up the road for 8,000 miles, hitting a 70 mile-per-hour clip. By that time the tires are worn. The car, of course, is good enough to finish the journey, but not at top speed."

The President laughed, "although a bit ruefully," and agreed to quit burning up the road — not down to 35 mph, but much less than 70 mph.

Despising mediocrity, he was never satisfied with less than excellence, and though he demanded much of himself and others, he maintained warm personal relationships.

Upon his return from the conference at Yalta (Figure 2), Roosevelt was advised to spend a month relaxing at the Little White House in Warm Springs, Georgia. He was felt to be doing well, into his second week of vacation, and had regained 8 of the 15 pounds he had lost in recent weeks. Dr. McIntire (who was attending a conference in Washington) had just called Dr. Paullin on April 12, 1945, arranging for a routine consultation visit to Warm Springs. Shortly thereafter, he (McIntire) received an emergency call from his assistant, Dr. Howard Bruenn, who was attending the President. Roosevelt had been chatting gaily with his cousins, and with Mrs. Elizabeth Shownatoff, an artist who was painting his portrait: ". . . while a laugh was on his lips, he complained of a terrible headache and collapsed in his chair." McIntire summoned Dr. Paullin, requesting that he race to the scene, 76 miles from Atlanta, under police escort.

The escort was hardly necessary, for Dr. Paullin was " . . . a veteran of many a wild night's ride through the Georgia countryside. (He) knew all the back roads and shortcuts (and) made the 76 miles in ninety minutes." In his own words:

"The President was in extremis when I reached him. He was in a cold sweat, ashy gray and breathing with difficulty. Numerous rhonchi in his chest. He was propped up in bed. His pupils were dilated and his hands slightly cyanosed. Commander Howard Bruenn had started artificial respiration. On examination his pulse was barely perceptible.

I gave him an intracardiac dose of adrenalin in the hope that we might stimulate his heart to acting. However, his lungs were full of rales, both fine, medium, and coarse, and his blood pressure was not obtainable. There were no effects from the adrenalin except perhaps for two or three beats of the heart which did not continue. Within five minutes after my entrance into the room, all evidence of life had passed away."

In an editorial a few years later, entitled "The Modern Physician at His Best," it was said that Dr. Paullin's attendance at Roosevelt's final illness got headlines, but was " . . . one of the lesser incidents in his career." He was ". . . far more famous for the depth of his wisdom and the breadth of his skill. To laymen he was known as a doctor who gave every case the same thorough attention he would give a stricken president."

Later Years

Dr. Paullin gave up his teaching position at Emory in 1950, after 35 years of meritorious service. His "long and faithful service as a teacher was characterized by punctuality of attendance, exactness of knowledge, and clearness of exposition." He was admired, respected, and esteemed by medical students. Emory medical alumni honored him with a scholarship to aid medical students.

On August 13, 1951, while taking a medical history in his office, Dr. Paullin was stricken with chest pain, and correctly self-diagnosed the pain pattern as an aortic dissection.

On August 13, 1951, while taking a medical history in his office, Dr. Paullin was stricken with chest pain, and correctly self-diagnosed the pain pattern as an aortic dissection. Among those in attendance was his son-in-law, William Minnich, M.D. Approaching the end, in true Oslerian spirit, he said, "My house is in order, and I am ready to go."

The funeral was simple, at his request, and devoid of flowers. Rev. Robert W. Burns presided, and mentioned how Dr. Paullin had given away hundreds of copies of Osler's *A Way of Life*. He also stated that in the recent months before his death, Dr. Paullin had cards printed, which he handed out to many of his patients, with a simple message:

"God, give me the serenity
To accept the things I cannot change
The courage to change all things I can,
And the wisdom to know the difference."

He closed with the following:

"Honor a physician according to thy need of him with the honors due onto him.
For verily the Lord hath created him.
For from the most High cometh healing;
The skill of the physician shall lift up his head;
And in the sight of great men, he shall be admired."

Summary

The legacy of the man lives on, years after his death. Physicians from his own hospital have held and will hold his former posts as president of the AMA and the American College of Physicians (Harrison Rogers and Nick Davies, respectively). Organizations that he helped start, the Southeastern Clinical Society and the Atlanta Clinical Society, continue to thrive. His high standards of medical care continue from a grandson-in-law (David Watson) and great-grandson (Brooks Lide).

To quote from Dr. R. Hugh Wood's letter in 1951:

"From the life of Dr. Paullin one may learn to better serve his profession and his country. Possessed of a keen intelligence, he took full advantage of his exceptional educational opportunities, and with vigor and persistence he lived a full life of service as physician, teacher, citizen, and friend."

Acknowledgement

Special thanks to Mrs. Caroline Minnich and Mrs. David Watson for sharing personal records of their father and grandfather, respectively.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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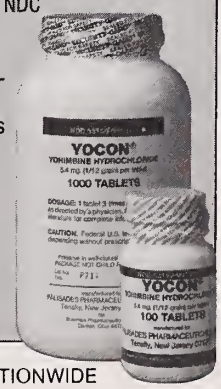

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Exertional Rhabdomyolysis in Two Prison Inmates

James T. Greene, M.D., David L. Anders, M.D.

Exercise-induced rhabdomyolysis occurs as a result of depletion of muscle energy by violent, exhaustive exercise which stresses the muscle beyond its normal capacity, apparently resulting in dissolution of the cell.

Introduction

MOST REPORTED cases of rhabdomyolysis are related to drug and alcohol abuse. Severe exertion leading to rhabdomyolysis was first recognized in 1910 and is usually diagnosed in the setting of rhabdomyolysis with a compatible patient history. We report two cases of exertional rhabdomyolysis and review its pathophysiology, complications, and treatment.

Case Reports

Case 1

A 30-year-old black male inmate from a local county correctional facility presented to the University Hospital emergency department on January 19, 1989, with complaints of hematuria and painful thigh, groin, and lower abdominal muscles. Bloody-appearing urine and tightness in his thighs began 2 days prior to admission. On the following day, he sought medical attention at the prison clinic, where he was treated with antibiotics for a presumed cystitis. Increasing pain in his thighs prompted the emergency room evaluation later that evening.

The patient denied any previous episodes of hematuria, urinary tract infections, or kidney stones. He did have a history of drug abuse, including intravenous heroin, but denied any use during the preceding 8 months, the length of his incarceration. He considered himself to be well conditioned, running 1 or 2 miles daily, and reported no recent change in level of activity. Otherwise, he denied recent trauma, fever, ethanol consumption, or seizures.

On physical examination, the patient was well developed and in no distress. He was afebrile with normal vital signs. The physical findings were remarkable only for tenderness on palpation of the quadriceps femoris muscles bilaterally, and slight tenderness of the lower abdominal muscles.

Laboratory studies including hemogram and serum electrolytes were obtained. Notable results included: blood urea nitrogen (BUN) 17 mg/dl, creatinine 1.1 mg/dl, phosphorus 3.3 mg/dl, lactic dehydrogenase (LDH) 33,800 IU/L, serum glutamic oxaloacetic transaminase (SGOT) 299 IU/L, and creatine kinase (CK) 338,800 IU/L. Urinalysis revealed amber colored urine with + + + protein and + +

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occult blood by dipstick method, with no erythrocytes seen on microscopic exam. A qualitative urine specimen obtained the following day was positive for myoglobin. A serum drug screen was negative for illicit drugs.

Large volumes of fluid may be necessary even in the absence of frank dehydration or volume depletion because of the associated capillary leak in the injured muscle bed.

The patient was admitted to the general medicine service for the treatment of rhabdomyolysis of undertermined etiology. Therapy was instituted with bed rest, liberal volumes of intravenous saline fluids and sodium bicarbonate for several days. The serum CK peaked at 1,528,000 IU/L on the day following admission, and normalized after 14 days. The diagnosis of exertional rhabdomyolysis was established on hospital day two, when a second patient (case report 2, below) provided additional historical information. The patient's urine had visibly cleared by the third day, and his thigh pain resolved after about 7 days of bed rest, although it was an additional week before he could walk comfortably. During the hospitalization, the patient showed no signs of acute renal failure, with the BUN remaining between 7 and 17 mg/dl, and the creatinine remaining between 0.8 and 1.2 mg/dl. The potassium, phosphorus, and calcium all remained within normal limits. After 14 days of hospitalization, the patient was transferred back to jail in good condition.

Case 2

A 29-year-old black male from the same prison facility presented to University Hospital emergency room on January 20, 1989, with complaints of bilateral thigh and calf pain. He reported that he had participated in a competition among his fellow prisoners consisting of repeating "squats," a form of calisthenics involving bending at the knees from a standing to a squatting position in rapid repetition. He estimated he and the patient above had performed 300-400 squats on both days 2 and 3 prior to admission. After the second day of squats, he noticed the gradual onset of dull aching myalgia in the major muscle groups of the lower extremities which was increased upon ambulation. Several hours prior to evaluation in the emergency department, he noted his urine becoming discolored, progressing from a dark orange to a coffee color. He denied illicit drug or ethanol abuse, recent trauma, fever, or seizure activity and was taking no medications.

Past medical history was negative for sickle cell anemia, urinary tract disorders, or previous muscular disorders.

On physical examination, the patient was in no distress, afebrile with normal vital signs. Physical findings were remarkable for bilateral lower extremity tenderness at the quadriceps femoris and gastrocnemius with minimum warmth to touch. Homan's sign was not present. Pulses were intact and of normal intensity. Neurologic examination revealed no abnormalities.

Laboratory data on admission revealed: BUN 12 mg/dl, creatinine 1.1 mg/dl, phosphorus 3.8 mg/dl, CK 139,500 IU/L. Urinalysis revealed brown hazy urine with + + protein and + + + occult blood by dip stick method with 1-4 erythrocytes per high power field on microscopic exam. Urinary drug screen was negative for amphetamine, cocaine, opiates, barbiturates, and phencyclidine. Serum myoglobin was greater than 1250 mg/ml.

The patient was admitted to the general medicine service for the treatment of exertional rhabdomyolysis. Therapy was begun with bed rest and intravenous saline fluids. Acetaminophen and cyclobenzaprine hydrochloride were prescribed as needed for pain. On the second hospital day, the serum CK peaked at 1,920,000 IU/L. On the fifth hospital day, the patient was noted to have mild edema of the left lower extremity. Distal pulses remained full, the neurologic exam remained intact, and ultrasound with pulsed doppler strain gauge plethysmography recorded no venous thrombosis. Tissue pressure measurements were not obtained. The edema resolved over the next few days. The serum CK dropped consistently until hospital day 9 when it leveled at approximately 5,000 IU/L for the next 3 days despite continued IV fluid therapy. On hospital day 12, the serum CK decreased to 2544 IU/L and IV fluids were discontinued. The CK continued to decline without IV fluids, and the patient was transferred back to jail in good condition on hospital day 14.

Discussion

Definition and Clinical Features

Rhabdomyolysis has been defined as "skeletal muscle injury, reversible or irreversible, that alters the integrity of the cell membrane sufficiently to allow escape of cell contents into extracellular fluid."[1] Rhabdomyolysis is very often subclinical, and with the common use of automated multi-serum analysis elevated levels of skeletal muscle enzymes may be discovered incidentally.[2] These enzymes include creatine kinase, muscle aldolase, glutamic oxaloacetic transaminase, and lactic dehydrogenase. Other intracellular contents which may be elevated include potassium, phosphorus, purines, and myoglobin. Rhabdomyolysis also results in myoglobinuria, which may or may not be visible (resulting in red or brown urine) depending on

several factors, including the amount of myoglobin released in the serum, the glomerular filtration rate, and the urine concentration.[1] Symptoms of rhabdomyolysis include weakness and myalgia of the affected muscles. Physical findings may include tender muscles, edema, or hemorrhagic discoloration of the affected muscles.[2]

Etiologic Agents

A very diversified group of agents may cause rhabdomyolysis, and exhaustive lists have beem compiled by other authors.[1,3] General categories include exertional states, traumatic and ischemic disorders, infective and inflammatory disorders, and metabolic and toxic disorders, including alcohol and drugs. Multiple factors are present in many patients.[1] In the United States, most of the reported cases are related to drug and alcohol abuse.[1, 4-6]

Exercise-Associated Rhabdomyolysis

Rhabdomyolysis associated with exertion has been recognized for many years. In 1910, Meyer-Betz presented the original report of pigmenturia and rhabdomyolysis related to exertion.[7] Exertional rhabdomyolysis has been well noted among military recruits.[8-10] The true incidence of exertional rhabdomyolysis is difficult to assess, due to probable under reporting. Howenstine reported 12 marine recruits out of a group of 28,000 who required hospitalization for exertional rhabdomyolysis associated with the "squat jump syndrome" in which marine recruits noted passage of dark urine in association with painful swelling and induration of the quadriceps muscles following excessive performance of the "squat jump" calisthenic.[11] Exercise induced rhabdomyolysis has also been reported in the civilian population following various types of exertion.[3, 8, 12]

Hypocalcemia is a frequent accompaniment of rhabdomyolysis with and without renal failure, even without hyperphosphatemia.

Pathophysiology of Muscle Damage

Inadequate energy metabolism is a mechanism for rhabdomyolysis in a variety of pathologic conditions, including exercise.[8] Exercise-induced rhabdomyolysis occurs as a result of depletion of muscle energy by violent, exhaustive exercise which stresses the muscle beyond its normal capacity, apparently resulting in dissolution of the cell, even in normal individuals.[2, 6] Co-morbid conditions, such as hyperthermia and volume depletion, may be contributing factors.

The type of exertion most associated with rhabdomyolysis is prolonged repetitive exercise of large muscle groups such as during calisthenics, including squat jumps.[10] The level of an individual's athletic training appears to be related also, with the highest incidence of rhabdomyolysis occurring in the least physically fit, and the lowest incidence among the most fit. Even a person who may have a high level of fitness in a general sense may still be at risk when performing specific exercises to which he has not been conditioned.[9] Glycogen depletion appears to play an important role in the pathogenesis of exercise-induced rhabdomyolysis. Untrained individuals may have a greater dependence on glycogen metabolism as a source of energy for exercising muscle than do trained individuals. Accordingly, they may also be more prone to glycogen depletion. During maximal exertion in the untrained, energy expenditure appears to be totally derived from extracellular glycogen stores, whereas trained individuals have an increased capacity to obtain energy from aerobic metabolism. Thus, high intensity exercise performed in the absence of muscle glycogen stores, as in poorly trained individuals or in the use of unconditioned muscles, may lead to deficient energy production in the muscle cell. This results in subcellar competition for available energy-yielding phosphates and a deficiency of energy necessary for membrane integrity, with the spectrum of structural damage ranging from reversible changes in membrane permeability to irreversible destruction resulting in cell death.[8]

Complications

Acute renal failure secondary to acute tubular necrosis caused by rhabdomyolysis is one of the most common causes of acute renal failure in the United States, accounting for approximately 5% of all cases of acute renal failure.[13] It is associated with all types of rhabdomyolysis including exertional rhabdomyolysis.[12] Factors predictive of acute renal failure in rhabdomyolysis include the degree of elevation of serum CK, calcium, and phosphate; the degree of depression of serum albumin level; the presence of a volume depletion; or sepsis as the underlying cause as determined by a prospective study of 157 patients with rhabdomyolysis due to various causes, 16.5% of whom develop acute renal failure.[14] The actual cause of renal failure in rhabdomyolysis is uncertain. Possible mechanisms have been proposed by several authors and include, among other things, direct nephrotoxic effects of myoglobin or its metabolites, tubular obstruction

by myoglobin or uric acid crystals, or renal vasoconstriction in response to various mediators, resulting in renal ischemia.[15] Renal failure due to exertional rhabdomyolysis is usually reversible[11] although deaths have been reported.[16]

The electrolyte abnormalities of rhabdomyolysis-related acute renal failure are similar to those of other causes of acute renal failure but may be more marked. The threat posed by these electrolyte abnormalities is a function of the attendant risk associated with the degree of abnormality, and not specific for rhabdomyolysis.[17] These include profound hyperuricemia and marked hypocalcemia during the initial phase with marked hypercalcemia during the latter phase.[1, 13, 17] Hypocalcemia is a frequent accompaniment of rhabdomyolysis with and without renal failure, even without hyperphosphatemia. Also, a more elevated anion gap is noted with rhabdomyolysis when compared to other causes of acute renal failure.[1] Hyperphosphatemia and hyperkalemia of rhabdomyolysis are similar to values found in other causes of acute renal failure.

Another complication of rhabdomyolysis is the development of acute compartment syndrome secondary to muscle swelling with the resulting neurovascular compromise, and a second wave of rhabdomyolysis. Tissue pressure measurements of involved muscle groups should be performed as soon as compartment syndrome is expected, even if pulses in neurologic functioning of the involved limbs remain intact, to allow for fasciotomy to avoid necrosis.[18] Fasciotomy was required in two of 87 cases of rhabdomyolysis of any cause reported by Gabow.[1] Disseminated intravascular coagulation can also be seen, and may be associated with severe hemorrhage, but usually resolves spontaneously after several days.[2]

Treatment

Treatment of rhabdomyolysis includes administration of large amounts of intravenous fluids, even as much as ten liters of normal saline in the first 12-24 hours. Large volumes of fluid may be necessary even in the absence of frank dehydration or volume depletion because of the associated capillary leak in the injured muscle bed. Diuretic therapy may be indicated with a single dose of mannitol, 25 grams intravenously, or furosemide, 200 mg intravenously as a single dose administered over ten minutes. Both serve theoretically to wash out the osmotic gradient in the renal medulla and thereby dilute the concentration of myoglobin.[2] Sodium bicarbonate infusion has also been recommended with the goal of solubilizing myoglobin in the renal tubules.[19] However, alkalinization of urine is difficult to achieve unless large quantities are used, which may aggravate hypocalcemia.[2]

Electrolyte abnormalities of rhabdomyolysis usually improve with intravenous fluid administration. Alarmingly abnormal levels or those associated with acute renal failure may be treated in a fashion appropriate for renal failure. In the presence of hypocalcemia, the effects of hyperkalemia may be accelerated. Hypokalcemia, which may be due to an increased propensity for calcium deposition in injured muscle, should probably not be treated unless systematic. Even without calcium replacement, approximately one third of patients with rhabdomyolysis and acute renal failure will develop transient hypercalcemia during recovery, perhaps due to extrarenal productin of 1, 25-dihydroxyvitamin D.[20] Morbidity and mortality are similar for rhabdomyolysis-associated renal failure and other types of acute renal failure.[1]

Summary

We have reported two cases of exertional rhabdomyolysis which resolved without serious complication. The denial and exclusion of significant historical information initially made the specific etiology of rhabdomyolysis indeterminate in the first case.

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Stepparents and Stepchildren: The Phaedra Complex

Alfred A. Messer, M.D.

As the incidence of divorce increases, so does the number of reconstituted families. Clinicians must be aware of the heightened potential for child sexual abuse in these situations.

You know this story: A man and woman marry when they are both 18. A daughter is born. Three years later they divorce. The child remains with the mother and sees the father every other weekend.

Time goes by. The couple each marry again, and each has children in their second marriage. The daughter of the first marriage sees her father and stepsiblings less and less. She helps her mother and stepfather care for her two stepbrothers who are 7 and 5 years younger than she. Both parents work.

Now the daughter is 13, and the mother has to work late two evenings a week. She and her stepfather cook supper together, feed the children, bathe them, and put them to bed. They jest about their "being like a married couple" and playfully begin to hug each other deeply after the two boys are safely asleep. They tease each other while they clear the table and put the dishes in the dishwasher.

A teenager wants to talk about her many feelings, and the stepfather is a willing listener. She tells him about the beginning interest in boys and the stepfather becomes testy. He insists she's too young for that, "you have to wait."

Sometimes when mother arrives home at 8:30 p.m., father and stepdaughter do not welcome her appearance. A minor disagreement escalates into a major squabble between the three. The girl goes to her room, angry; the argument between the parents continues far into the night.

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Only the next evening, during a period of harmony, do both ask each other, "What on earth were we fighting about last night?"

Perhaps they're not paying attention to a natural phenomenon: "family romance." In the safety and warmth of the family setting, a growing child experiments with every sensation and feeling, including coyness and flirtation.

A young boy wants to woo his mother, a young girl tries to woo her father. There's a natural rivalry that springs up between the child and parent of the opposite sex. How often are parents sitting on a sofa and their 3-year-old child tries to separate them by sitting in-between?

As the child begins to be aware of sexual feelings, the first object of phantasy is the parent of the opposite sex. Sigmund Freud used the classic Greek legends to describe the Oedipus and Electra complexes. This sexual attraction (incestuous) eventually culminates in the youngster renouncing this incestuous feeling and seeking het-

erosexual relationships outside the family. To Freud, how each child resolved their respective complexes had much to do with the child's later character and temperament.

The taboo against incest is probably the single taboo that is universal. It serves as a modulating force in "family romance": parents and their natural children do not step over the line sexually.

But what happens when there are stepparents and stepchildren, where there are no blood ties? Here we recall another Greek legend, the story of Phaedra. Phaedra was a young Cretan woman who married an older King Theseus and fell in love with his son of a previous marriage, Hippolytus. Tragedy resulted, and all three were killed. A more contemporary version of this theme is Eugene O'Neill's *Desire Under the Elms*. The Phaedra Complex is to the stepparent-stepchild reaction as the Oedipus and Electra Complexes are to natural parent-child interaction.

As the incidence of divorce increases, so does the number of reconstituted families. Clinicians must be aware of the heightened potential for child sexual abuse in these situations. In order to minimize pathologic stepparent-stepchild reaction, to deal with the Phaedra Complex appropriately, several avenues exist.

Where an absent parent raises no objection, legal adoption reinforces the incest taboo. Similarly, the use of names is important. First names denote equality, "Mother" and "Father," even "Stepmother" and "Stepfather" denote generational difference. So does disciplining of children.

If a stepparent is a guest in a household rather than a functioning parent, separation between generations may also be diminished, particularly as boys and girls grow into the blush of adolescence. We try to avoid situations where a stepparent and stepchild of the opposite sex are cast into complementary parenting roles, as in the clinical example cited.

In any marriage, be it first or second or third, parents should spend time alone away from the children to invigorate the marital bond. This serves to lessen the need for either parent to seek some form of "romantic gratification" through the children.

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Access to Medical Care: A Perspective of Internal Medicine

Albert A. Carr, M.D.

THREE YEARS of approved post medical school graduate education and training are a basic requirement for the internal medicine specialty. This base produces physicians called internists who are highly skilled in evaluation and management (E/M) across the broad spectrum (simple to complex) of human diseases, dysfunctions, and health problems.

This education and training provides other subspecialty opportunities in internal medicine such as allergy, cardiology, endocrinology, gastroenterology, hematology, nephrology, oncology, pulmonary medicine, and rheumatology.

In Georgia and the United States, internists provide one third of the primary and comprehensive medical care of adults in addition to consultation and concurrent medical care in conjunction with other physicians. Internists are the mainstay of medicine for medical care, teaching, and medical research.

Primary or comprehensive medical care provides an ongoing (years) relationship between a physician and patient for the evaluation and management, prevention (early detection), and rehabilitation of both acute and chronic medical-health problems. The primary care physician keeps meaningful records in chronologic order and provides personal care and when needed obtains consultative and concurrent care from other physicians.

Internal medicine primary care physicians provide:

- Patient-oriented rather than disease-oriented medical care
- Ongoing (years) care and record keeping
- Evaluation and management for prevention, acute and chronic medical problems, and rehabilitation
- Advice for maintenance of good health
- Access to consultative and concurrent medical care (most often surgery and special diagnostic tests
- Medical care in an office (majority) hospital or emergency setting.

It is important for those interested in the future of medicine to read in detail both the ACP and ASIM proposal and position papers. The problems in Georgia with HCFA, AEtna, and HealthCare Compare make it difficult to imagine a single payer such as the federal government could operate a reasonable and workable system.

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Medical care is the scientific approach to evaluation and management (E/M) for real or perceived medical-health problems. It is controlled by a physician in conjunction with the patient (the person with the real or perceived medical-health problem).

It embodies an enduring physician-patient relationship of mutual trust, confidentiality, and meaningful communication. The physician is the advocate for the patient's sense of well being, comfort, and best possible outcome. This outcome relates not only to the medical problem but also the psychologic and economic well being of the patient.

It is the physician's obligation to provide evaluation and management at the lowest possible cost in dollars in relation to effectiveness or outcome not in dollars. This requires skills in evaluation and management and knowledge of outcome information related to costs. Cost-effectiveness is of importance to the physician-patient relationship and can be influenced by the internist.

Internists have little control over the charges of other physicians, hospitals, many diagnostic tests and medications. However, they should and do have knowledge of *cost-effectiveness* for evaluation of management of medical problems. This knowledge helps them make prudent decisions which influence cost-effectiveness.

The cost in dollars for the evaluation and management of a patient with high blood pressure for the best possible effectiveness is an example of *cost-effectiveness*. Effectiveness (outcome) is not measured in dollars. It is measured by the control of blood pressure and prevention of hypertensive and atherosclerotic complications, quality of life (sense of well being and ability to perform usual activities), and adverse reactions compared to none or some other method of evaluation and management.

In contrast, *cost-benefit* is a concept which involves diseases rather than individuals and the cost to society. It is the cost in dollars for the evaluation and management of a disease or medical problem in relation to the benefits in dollars.

The cost of evaluation and management of atherosclerotic heart disease with heart transplant in relation to the benefits in dollars is an example of *cost-benefit*.

The benefits in dollars are measured as the dollar value for the number of productive years of employment and in the dollar value for reductions in the incidence of medical complication, as compared to none or different evaluation and management.

It is obvious for some illnesses that the costs of evaluation and management far exceed the dollar value of benefits. Heart transplant is such an example. This concept also involves decisions whether to treat for advanced cancer or prolong life of hospitalized patients with terminal illnesses.

Cost-benefit is an important topic for the formulation of public policy and for third parties which pay for medical evaluation and management (insurance companies, businesses, and government). It places a dollar value on human life. Physician-internists cannot be concerned about *cost-benefit* as an advocate for a patient. Physicians must be concerned only with *cost-effectivess* when involved in the evaluating and management of an individual patient. It is conflict of interest to be concerned about *cost-benefit* while involved in an physician-patient relationship.

Society at large has to be concerned with *cost-benefit* and place a "price" in dollars on human life and suffering. The physician role is advocate for the patient's well being, comfort, as best possible outcome. That outcome relates not only to diseases but to psychologic and economic well being.

Cost-benefit denotes health care of society which includes social, economic, and environmental influences. It relates to public policy, businesses and payers of medical insurance.

Cost-effectiveness relates to the individual physician-patient relationship. It is against waste and for profit concerns in medical evaluations and management. It is related to medical care of individuals.

In Georgia and the United States, there is unequal access to medical care. The poor or near poor suffer the most because of this lack of access. The greatest risk factor for premature deaths or morbidity from diseases is poverty. Many states are trying to address the problem with some form of basic or minimum of medical care.

Internists who belong to the Georgia and American Societies of Internal Medicine believe basic services should cover:

- Physician services
- Inpatient and outpatient hospital services
- Laboratory and X-ray services
- Prescription drugs
- Institutional care for elderly and the physically and mentally disabled
- Dental services
- Early and periodic screening, diagnosis and treatment services (EPSDT)
- Family planning — pre and perinatal care
- Home health and personal services
- Other medically necessary professional services.

It is obvious that the lowest *cost-effectiveness* ratio should be used for a minimum service. However, the public at large via the legislative process is now aware of the costs. Choices need to be made related to to *cost-benefit*. Should heart transplants or wasteful chemotherapy for advanced cancer be offered in a minimum medical care description?

In most states, Medicaid does not cover a large portion of the population needing medical care. In

Oregon, Senate Bill 27 of the 1989 Oregon Legislative Assembly (regular session) presented by the Senate President, John Kitzheber, M.D., is a plan formulated to provide the poor access to medical care. It is a rationing of medical care for the poor depending on funds available.

Basically, it will provide health services for those families with incomes below the federal defined poverty level. These health services are:

1) provider services and supplies
2) out patient services
3) inpatient hospital services
4) health promotion and disease prevention services.

These services will be used to provide medical assistance to the needy via the old Medicaid system but with expanded numbers of those eligible for the services. The services will be provided by a prepaid managed medical-health care system on a capitation system of payment.

The Oregon plan differs from others in that a Health Services Commission established priorities of medical-health care services from the most to least important in terms of benefits. The commission consists of 11 members: 5 physicians, 1 public health nurse, 1 social services person, and 4 consumers all appointed by the Governor. Subcommittees can be appointed by the Health Services Commission. Deliberations of the committee and subcommittee members and public forums are to establish a consensus (not defined) on values to be used to guide resource allocation decisions.

Once priorities are established, services will be provided to all who are eligible. The services provided depend on the funds available. When funds are limited or expended the lower priority services will be deleted.

The Oregon plan in a way enhances the inequities of medical care providing less for greater numbers of poor. This is because greater numbers are to be provided with medical assistance with the same amount of funds. Therefore, lower priority services by necessity will be excluded. If the priority services were defined and the monies necessary to provide them allocated, the Oregon system would be fair for the poor. As it stands, it further discriminates against the poor by providing less and prioritized medical care. This system abolishes the usual physician-patient relationship in medical care.

The 1990 Session of the Georgia General Assembly addressed the problem of unequal access to group health insurance. House bill 1609 was designed to allow insurance companies and employees of 24 or fewer persons to enter insurance contracts which would provide only those benefits for services for which all mutual parties agreed. The legislative process became complicated, and the bill was not passed.

The leadership of internist members of the American Society of Internal Medicine (ASIM) and the American College of Physicians (ACP) each recently published their proposals and position papers on how to improve access to and payment for evaluation and management (E/M) of health and diseases for those Americans underinsured or without insurance.

ASIM — Ending Separate and Unequal Health Care; Proposals of The American Society of Internal Medicine; April 1990, pages 1-28. Request for reprints: ASIM, 1101 Vermont Avenue, NW, Suite 500, Washington, DC 20005-3457.

ACP — Access to Health Care, Executive Summary; Position Paper. Annals of Internal Medicine 1990; 112:641-661, May 1, 1990. Request for reprints: Department of Public Policy; American College of Physicians, 700 13th Street, NW, Suite 250, Washington, DC 20005.

The ACP position paper is more a discussion of six major possible proposals for extending health insurance protection, without specific details on implementation. These six proposals are:

1. Encourage individuals and employers to purchase private insurance
2. Mandate employer coverage
3. Create health insurance risk pools
4. Extend Medicaid eligibility
5. Expand charity care
6. Establish a universal access to health insurance program.

The ACP position supports a nationwide program of basic (not defined) evaluation and management of health and diseases of all Americans via a nationwide health insurance and funding system. The funding is to be generated by general tax revenues or a surcharge on income taxes or payroll taxes or income related premiums. The ACP position seems to support the sixth proposal and implies the need for a complete change from the present private/public payers system to a single-payer system. The federal government will be the most likely candidate for payer. The ACP position to support the sixth proposal does not build on the positive aspects of our present system. The ACP position, in contrast to that of ASIM, does not make specific proposals and does not, as does ASIM, endorse the proposals of the Steering Committee of a 21-member Access To Health Care Coalition of national medical specialty groups, the AMA, and the U.S. Bipartisan Commission On Comprehensive Health Care (Pepper Commission). The Pepper Commission proposals are:

1) Universal access to payment for basic (to be defined) evaluation and management of health and disease program

2) Mandated employer provision of health insurance for employees and dependents with employee cost-sharing when possible, some tax relief for employers, when needed, subsidies and state risk pools.

3) Expansion and improvement of Medicaid

4) Provisions for participation in a subsidized program for those not eligible for employer programs or Medicaid.

The specific ASIM proposals are as follows:

A. Expansion of Employer-based Health Insurance.
   1. Require employers to offer employees a health insurance program which covers basic (defined) evaluation and management of health and diseases.
   2. Provide special assistance to small businesses to make the cost of the insurance affordable and not a burden.
      a) Allow for an appropriate phase-in of the requirement;
      b) Designate regional insurers and establish risk pools;
      c) Allow businesses to substitute an actuarially equivalent plan for the required insurance;
      d) Provide a federal subsidy in hardship cases;
      e) Pre-empt state laws that mandate minimum benefits;
      f) Permit full tax deductions for the costs of the insurance premiums.
   3. Reform the health insurance market by prohibiton of experience rating and pre-existing condition exclusions. Establish special rules for marketing to small groups. Once market reforms are functional along with expansion of Medicaid and a mandate that employers provide health insurance for their employees, all individuals should be required to offer evidence of having obtained insurance to cover basic health and disease medical needs.
   4. Provide tax incentives for individuals to set aside funds to pay for evaluation and management of health and diseases expenses in order to supplement financing from employer-based health insurance and public programs.

B. Improving and Expanding Public Financing
   1. Convert Medicaid from a welfare type program to a source of funding for all individuals, who are unable to obtain employer-mandated health insurance; regardless of income.
      a) Mandate national uniform eligibility standards;
      b) Require individuals with income above the poverty level to contribute some of the insurance or evaluation and management cost by premiums, deductibles or co-payments. The level of individual contribution to be based on a sliding scale of income.
   2. Mandate a defined minimum or basic evaluation and management of health and diseases to be covered or payed for by the Medicaid program.
   3. Reform physician payment under the Medicaid Program to insure incentives for adequate physician participation and to introduce proper incentives into the system.
   4. Increase federal government fundings for the expanded Medicaid program to reduce the financial burden on the states.

C. Providing Coverage for Long-term Care
   1. Encourage the availability of private long-term care insurance:
      a) Apply the same tax status to long-term care products as now exists for accidental death and dismemberment insurance and health insurance;
      b) Allow the deductibility of insurance reserves and related investment earnings and permit the inclusion of long-term care coverage in cafeteria plans;
      c) Eliminate restrictions on the prefunding of retiree health benefits and long term care insurance.
   2. Provide a sliding subsidy to enable low income beneficiaries to purchase private long-term care insurance.
   3. Provide for federal and state regulations that enhance consumer protections in the long-term care market.
      b) Assure appropriate standards of coverage;
      c) Provide protections against sales abuses;
      d) Assure requirements for sufficient reserves;
      e) Develop benefit premium rates.
   4. Provide an asset protection program for individuals who purchase long-term care policies as an incentive to purchase private long-term care insurance.
   5. Establish a new Medicare benefit to assist individuals in paying for long-term care. The program should:
      a) Provide adequate cost sharing by individuals;
      b) Protect against depleting personal assets;
      c) Have premium contributions on a sliding scale basis.

D. Health Care Cost and Other Barriers to Access
   1. In order to assure that money spent on evaluation and management of health and diseases is spent wisely and effectively the medical profession with the cooperation of government and other payers should:
      a) Place high priority on studying the outcomes of different medical evaluation and management interventions;
      b) Develop practice guidelines to modify physician behavior and provide a basis for setting payment criteria (unit cost and volume).

2. Eliminate administrative hassles that impede access to care.
3. Institute reforms in the medical liability system.
4. Require some level of patient cost sharing in all insurance plans.

It is important for those interested in the future of medicine to read in detail both of these proposals and position papers. The problems in Georgia with HCFA, AEtna, and HealthCare Compare make it difficult to imagine a single payer such as the federal government could operate a reasonable and workable system.

The ACP position paper really is not very specific. In contrast, the ASIM proposals are for improvement of our private/public problems with specific guidelines and even cost estimates.

The time is now for Georgians and Americans to decide if we will be a humane society and provide reasonable medical care for all including the poor. It makes no sense to be overly concerned about whether 12% or more of our gross national product is expended for medical care!

We spend large sums of monies for entertainment and material things not needed as much as medical care. We also spend large amounts of money on cigarettes, alcohol, and illegal mind-altering drugs. Certainly these are hazards to our health and not needed. Our priorities need to be directed toward treatment and prevention of medical problems and promotion of health. We probably should spend more rather than less of our resources for better and healthier lives. We can afford up to 20-25% expenditures of our gross national product for medical-health care. Such expenditures are worthwhile. These expenditures create many jobs and should be healthy for our lives and economy.

Any plan which makes available medical care through insurance must define basic medical needs for all. More than likely an insurance system of around $2,000 per year per family will cover the basic *cost-effective* medical care needs. Once the basic medical needs (minimum) are described, actuarial data will determine if the $2,000 figure is close.

Continuation and strengthening the physician-patient relationship is essential for the humane approach to medical care. The physician must be the advocate for the patient's well being. Internists, both as primary care and specialty physicians who provide a significant portion of medical-health care are concerned about unequal access to medical care in Georgia today.

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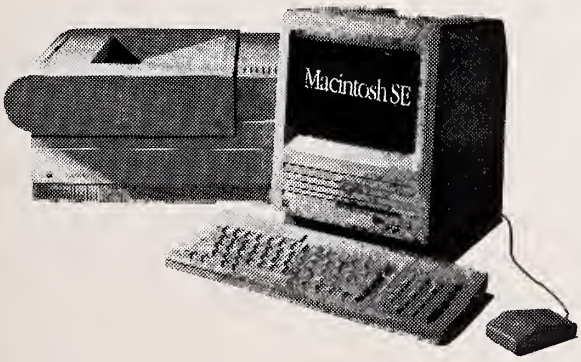

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GENERAL INFORMATION

RITZ-CARLTON BUCKHEAD HOTEL
November 16-18
Atlanta

ABOUT THE MEETING

This year's MAG Scientific Assembly features clinical sessions in fourteen specialties: allergy and immunology, cardiology, emergency medicine, internal medicine, neurology, neurosurgery, obstetrics and gynecology, occupational medicine, ophthalmolgy, orthopaedic surgery, otolaryngology, pathology, plastic surgery and psychiatry. Each of these programs has been arranged by its respective specialty society, with topics and speakers likely to be of most interest and pertinence to members.

REGISTRATION INFORMATION

Registration for the MAG Scientific Assembly allows a physician to attend any and all CME programs held during the weekend. To register for these scientific meetings, please complete the registration form inserted in this **Journal**, detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

REGISTRATION FEE

	MAG Member	Non-Member
Physician	$80	$125
Resident Physician	No fee	
Medical Student	No fee	
Other Health Professional	$40	
Program Chairmen or Speakers	No fee	

If you need more registration forms, call the MAG office in Atlanta (876-7535 or toll free in Georgia: 800/282-0224). We will gladly mail you as many as you need. Early registration is advised. General registration desks will also be open at the Scientific Assembly Friday 8:00AM–4:00PM; Saturday 8:00AM–4:00PM; and Sunday 8:00AM–Noon.

SPECIAL "BONUS" PROGRAM: DEPRESSION IN PRIMARY CARE PATIENTS

Numerous studies over the past decade have shown that most individuals who seek care for mental health problems turn first to their primary care physicians. In addition, large numbers of patients with depressive illnesses seek care complaining of physical symptoms. These facts, together with recent results from the Medical Outcomes Study showing that the disability associated with depression is as great as it is for several chronic physical illnesses, mean that it is imperative for primary care physicians to recognize and care for their depressed patients.

The American Medical Association, with funding from the National Institute of Mental Health's Depression/Awareness, Recognition and Treatment Program, is pleased to offer a half-day workshop on depression for the primary care physician as a part of the Medical Association of Georgia's Annual Scientific Assembly. The program will provide up-to-date information on diagnosis and treatment of depressed patients as well as discussion of such special topics as geriatric patients and mixed presentations like anxiety and depression.

Registration is free and open to all paid registrants to the Medical Association of Georgia's Annual Scientific Assembly. Others wishing to attend may register at the following rate:

$20 AMA members
$30 Non-members

LODGING

If you wish hotel accommodations at the Ritz-Carlton, please complete and detach the bottom portion of the registration form and mail it directly to the Ritz-Carlton Buckhead Hotel. Reservations received by the hotel after October 24 will be met on a space-available basis.

PROGRAM OBJECTIVES

The specialty society programs of the MAG Scientific Assembly are intended to provide the practicing physician with current clinical information on pertinent topics. Each of the specialty programs has been planned by a Program Chairman from the respective specialty societies, based on the educational needs and interests of his or her colleagues.

ALLERGY

ALLERGY & IMMUNOLOGY SOCIETY OF GEORGIA

Friday, November 16

Luncheon—12:00-1:20PM
Meeting—1:30-5:00PM

PROGRAM CHAIRMAN:

Chester T. Stafford, M.D.
Medical College of Georgia, Augusta, Georgia; Vice President, Allergy & Immunology Society of Georgia

FACULTY:

Philip Fireman, M.D.
Professor of Pediatrics, University of Pittsburgh; Director, Allergy-Immunology/Rheumatology; Children's Hospital, University of Pittsburgh, Pittsburgh, Pennsylvania (Sponsored by Janssen Pharmaceutica)

John W. Georgitis, M.D.
Associate Professor of Pediatrics, Bowman Gray School of Medicine, North Carolina Baptist Hospital, Winston-Salem, North Carolina (Sponsored by Marion Merrell Dow Pharmaceutical, Inc.)

Jose Dominguez, M.D.
Fellow, Emory University School of Medicine, Atlanta, Georgia

Ned T. Rupp, M.D.
Fellow, Medical College of Georgia Hospital and Clinics, Augusta, Georgia

Mary H. Anderson, M.D.
Fellow, Medical College of Georgia Hospital and Clinics, Atlanta, Georgia

Steven L. Wise, M.D.
Fellow, Medical College of Georgia Hospital and Clinics, Atlanta, Georgia

Friday Afternoon

12:00–1:20
Luncheon—Sponsored by Schering Laboratories Scientific Meeting

1:30–2:15
Increased Asthma Morbidity and Mortality—A Need for Early Recognition
Philip Fireman, M.D.

2:15–2:30
Update on Exercise-Induced Asthma Research Studies
Ned T. Rupp, M.D.

2:30–2:45
Safety and Efficacy of Fire Ant Venom in the Diagnosis of Fire Ant Allergy
Steven L. Wise, M.D.

2:45–3:00
Coffee Break Sponsored by Muro Pharmaceutical, Inc.

3:00–3:45
IgG Subclasses—What is Their Clinical Relevance?
John W. Georgitis, M.D.

3:45–4:00
Chronic Neutropenia—Case Report
Jose Dominguez, M.D.

4:00–4:15
Imaging Techniques in the Diagnosis of Sinusitis
Mary H. Anderson, M.D.

4:15–5:00
Business Meeting
Members of the Allergy & Immunology Society

5:00
Adjourn

We gratefully acknowledge the generosity of Janssen Pharmaceutica for its sponsorship of Dr. Fireman, and the generosity of Marion Merrell Dow Pharmaceutical for sponsoring Dr. Georgitis. We are thankful for Schering Laboratories' sponsorship of our luncheon, and for Muro Pharmaceutical, Inc. sponsoring the coffee break.

CARDIOLOGY

GEORGIA CHAPTER AMERICAN SOCIETY OF CARDIOLOGY

Saturday, November 17

8:00AM-2:30PM

PROGRAM CHAIRS:

Gary W. Olson, M.D., Dalton
Marsha J. Certain, M.D., Brunswick

FACULTY:

R. Wayne Alexander, M.D., F.A.C.C.
Chief of Cardiology, Emory Univerisity School of Medicine, Atlanta, Georgia

Thomas F. Deering, M.D., F.A.C.C.
Private Practice, Atlanta, Georgia

Paul V. Ginsberg
Executive Director, Physician Payment Review Commission, Washington, D.C.

Spencer B. King, III, M.D., F.A.C.C. Director, Interventional Cardiology Emory University School of Medicine, Atlanta, Georgia

Allan M. Ross, M.D., F.A.C.C.
Director, Division of Cardiology George Washington University Medical Center Washington, D.C.

Charles I. Wilmer, M.D., F.A.C.C.
Private Practice Atlanta, Georgia

Saturday Morning

8:00–8:30AM
Annual Business Meeting-Georgia Chapter, American College of Cardiology

8:30–9:00
Endothelial Dysfunction and Ischemic Coronary Syndromes: From the Laboratory to the Bedside
R. Wayne Alexander, M.D., F.A.C.C.

9:00–9:15
Questions

9:15–9:45
What's New in the Early Treatment of Acute Myocardial Infarction
Allan M. Ross, M.D., F.A.C.C.

9:45–10:00
The First Hour Program in Georgia—A Joint ACC/AHA Project
Charles I. Wilmer, M.D., F.A.C.C.

10:00–10:15
Questions

10:15–10:45
Coffee Break

10:45–11:15
New Interventional Strategies in the Treatment of Coronary Artery Disease
Spencer B. King, III. M.D., F.A.C.C.

11:15–11:30
Questions

11:30–12:00
Anti-Arrhythmic Therapy: What's New in Drugs and Devices?
Thomas F. Deering, M.D., F.A.C.C.

12:00–12:15PM
Questions

12:15–1:00
Medicare Physician Payment Reform: Implications for the Cardiologist
Paul V. Ginsberg

1:15–2:30
Luncheon

Depression in Primary Care Patients

SPONSORED BY THE AMERICAN MEDICAL ASSOCIATION DEPARTMENT OF MENTAL HEALTH

Saturday, November 17

9:00AM–12:30PM

FACULTY:

Steven Cohen-Cole, M.D.
Wesley Woods Geriatric Hospital; Department of Psychiatry, Emory University School of Medicine, Atlanta

Saturday Morning

The AMA "Depression in Primary Care Patients" seminar is free to all registrants of the Scientific Assembly, and open to all other physicians at a nominal cost. (Please refer to the MAG Scientific Assembly Registration Form.)

This workshop is supported in part by a grant from the Depression/Awareness, Recognition and Treatment Program of the National Institute of Mental Health. The D/ART Program is a multiphase information and education program designed to alert health professionals and the general public to the fact that depressive disorders are common, serious and treatable.

EMERGENCY MEDICINE

GEORGIA CHAPTER AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Saturday, November 17

Meeting-8:30AM-12:00PM
Luncheon-12:00-2:00PM

PROGRAM CHAIRMAN:

Richard O. Shields, Jr., M.D., F.A.C.E.P.
Board of Directors, Georgia ACEP, Department of Emergency Medicine, Memorial Medical Center, Savannah, Georgia

FACULTY:

Lewis Goldfrank, M.D.
Director of Emergency Medical Services, Bellevue Hospital Center, New York University Medical Center, Medical Director; New York City Poison Control Center

Saturday Morning

8:30–8:35
Welcome and Introduction
Walter E. Limehouse, M.D., President, Georgia Chapter, American College of Emergency Physicians

8:35–9:45
Pharmacology, Toxicology and Social Impact of Cocaine
Lewis Goldfrank, M.D.

9:45–10:00
Questions and Discussion

10:00–10:30
Coffee Break

10:30–11:30
The Impact on Emergency Departments of AIDS and the Homeless

11:30–12:00
Panel Discussion/Questions

12:00–2:00
Luncheon—Members of the Georgia Chapter, ACEP

INTERNAL MEDICINE

GEORGIA SOCIETY OF INTERNAL MEDICINE

Friday, November 16

1:00PM-4:45PM

PROGRAM CHAIRMEN:

Albert A. Carr, M.D.,
Augusta—President
Harry N. Dorsey, M.D.,
Albany—Vice President

FACULTY:

Yank D. Coble, Jr., M.D.
Trustee, American Society of Internal Medicine; Past President, Florida Society of Internal Medicine and Florida Medical Association, Jacksonville, Florida

James K. Van Buren, M.D.
Past President, Georgia Society of Internal Medicine; Private Practice of Internal Medicine and Pulmonary Diseases, Albany, Georgia

Harry N. Dorsey, M.D.
Vice President, Georgia Society of Internal Medicine; Private Practice of Internal Medicine, Albany, Georgia

James R. Lyle
President/CEO, HealthCare Consultants, Inc. and Physician Billing Services, Inc., Augusta, Georgia

Friday Afternoon

1:00–1:30PM
The Hassle Factor—How to Fight and Win
Yank D. Coble Jr., M.D.

1:30–1:45
Discussion—Q&A

1:45–2:15
Honorable J. Roy Rowland's Bill: Medicare Physician Regulation Relief Amendments of 1990

1) Release of information before notice of denial
2) Flexibility in billing arrangements in cases of certain physicians' "covering"
3) Release of certain carrier information without charge
4) Medical Society representation of physicians in appeal
5) Practicing Physicians Advisory Council

2:15–2:30
Discussion— Q&A

2:30–3:00
ICD-9-CM Link to CPT Codes for Reimbursement—How to Make the System Work for You
James R. Lyle

3:00–3:15
Discussion—Q&A

3:15–3:30
Break

3:30–4:00
Federal Regulation of Physicians' Office Laboratories
James K. Van Buren, M.D.

4:00–4:15
Discussion—Q&A

4:15–5:00
Consultations & Concurrent Care—A Panel Discussion
Harry N. Dorsey, M.D., Moderator

NEUROLOGY

GEORGIA NEUROLOGICAL SOCIETY
Saturday, November 17
Meeting—9:00AM-3:00PM
Luncheon—12:00-1:00PM

PROGRAM CHAIRMAN:
Noel Holtz, M.D.
President, Georgia Neurological Society, Marietta, Georgia

FACULTY:

Peter J. Dyck, M.D.
Mayo Medical School, Rochester, Minnesota

Michael J. Glantz, M.D.
University of Minnesota Medical School

Linton C. Hopkins, M.D.
Department of Neurology, Emory University School of Medicine, Atlanta, Georgia

Ray L. Watts, M.D.
Department of Neurology, Emory University School of Medicine, Atlanta, Georgia

Saturday Morning

9:00–10:00AM
Immune Neuropathies: New Insights and Treatment
Peter Dyck, M.D.

10:00–10:45
Current Treatment of Brain Malignancies
Michael Glantz, M.D.

10:45–11:00
Coffee Break

11:00–12:00
Recent Advances in Parkinson's Therapy
Ray L. Watts, M.D.

12:00–1:00
Luncheon for Society Members

1:00–2:00
Etiology of Developing Seizures
Michael Glantz, M.D.

2:00–2:30
Use of Nerve Conduction and EMG in the Diagnostic Evaluation of Neuropathy
Linton Hopkins, M.D.

2:30–3:00
Questions and Answers

We gratefully acknowledge the support of CIBA-GEIGY Pharmaceuticals in sponsoring Dr. Glantz's presentation.

NEUROSURGERY

GEORGIA NEUROSURGICAL SOCIETY
Saturday, November 17
9:00AM-1:00PM
Sunday, November 18
8:00AM-12:00NOON

PROGRAM CHAIRMAN:
Gerald N. Kadis, M.D.,
Thomasville, Georgia

HONORED GUEST SPEAKER:
Bennett Stein, M.D.
Professor of Neurosurgery, Columbia Presbyterian Medical Center, New York, New York

Saturday Morning

AVM's of the Brain
Bennett Stein, M.D.

Case Presentations by Members of Georgia Neurosurgical Society

Sunday Morning

Pineal Region Tumors
Bennett Stein, M.D.

Business Meeting—Georgia Neurosurgical Society

OBSTETRICS-GYNECOLOGY

GEORGIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Friday, November 16
Meeting—1:00PM-5:00PM

PROGRAM CHAIRMAN:

Thomas Nolan, M.D.
Augusta, Georgia

FACULTY:

Stuart T. Brown, M.D.
Decatur

Matthew O. Burrell, M.D.
Atlanta

Lawrence C. Layman, M.D.
Medical College of Georgia School of Medicine

Hugh W. Randall, M.D.
Emory University School of Medicine

Friday Afternoon

1:00–1:45PM
Pap Smears, the Bethesda Classification and HPV
Matthew O. Burrell, M.D.

1:45–2:30
Syphilis: Changes in Epidemiology and Therapy
Stuart T. Brown, M.D.

2:30–2:45
Questions

2:45–3:15
Break

3:15–4:00
Habitual Abortion and Lupus Anticoagulation
Lawrence C. Layman, M.D.

4:00–4:45
Crack Cocaine and Pregnancy
Hugh W. Randall, Jr., M.D.

4:45–5:00
Questions

5:00
Adjourn

OCCUPATIONAL MEDICINE

GEORGIA CHAPTER, AMERICAN COLLEGE OF OCCUPATIONAL MEDICINE
Friday, November 16
Meeting—1:00PM-5:00PM

PROGRAM CHAIR:

Carol H. Oster, M.D.

FACULTY:

Howard Frumkin, M.D., M.P.H.
Assistant Professor of Medicine, Clinical Epidemiology Unit, University of Pennsylvania School of Medicine, Philadelphia

Stephen A. Dawkins, M.D.
Atlanta

Ron Huggins, Ph.D., M.P.H.
Emory University School of Public Health

Friday Afternoon

PRESIDING:

Fredric C. Glass, M.D.
President

1:00–2:15PM
Investigating a Suspected Cancer Cluster in the Work Place
Howard Frumkin, M.D., M.P.H.

2:15–3:30
Health and Safety Issues in the Health Care Industry—Hepatitis, Herpes, AIDS, Medical Waste Disposal
Ron Huggins, Ph.D., M.P.H.

3:30–4:00
Break

4:00–4:30
Pulmonary Alveolar Proteinosis: A Possible Sequela of Nitrogen Dioxide Exposure
Stephen A. Dawkins, M.D.

4:30–5:00
Business Meeting

OPHTHALMOLOGY

GEORGIA SOCIETY OF OPHTHALMOLOGY
Saturday, November 17
Meeting—8:30AM-3:50PM

PROGRAM CHAIRMAN:
David S. Hull, M.D.
Augusta

GUEST SPEAKER:
Richard Lindstrom, M.D.,
Clinical Professor of Ophthalmology, University of Minnesota Medical School; Attending Surgeon, Phillips Eye Institute and Minneapolis VA Medical Center

Saturday Morning

Session #1
8:30AM
David S. Hull, M.D., Moderator

8:30
Lacrimal Intubation Made Easy
Ted H. Wojno, M.D.

8:40
Combined Orbital Neurosurgical Approach for Optic Nerve Tumors
Clinton D. McCord, Jr., M.D.

8:50
Interactions of Benzalkonium Chloride with Soft and Hard Contact Lenses
Jack Chapman, M.D.

9:00
Discussion

9:10
Guest Lecture: Current Concepts in Posterior Chamber Implants
Richard Lindstrom, M.D.

9:40
Discussion

10:00
Behcet's Syndrome Masquerading as Fungal Endophthalmitis
William S. Hagler, M.D.

10:10
Pars Plana Vitrectomy without Scleral Buckle for Pseudophakic Retinal Detachment, Part II
Edwin H. Donnelly, M.D.

10:20
Juxtapapillary Capillary Hemangiomas
Barry E. Wright, M.D.

10:30
Discussion

10:40
Coffee Break

Session #2
Sumner Fishbein, M.D., Moderator

11:10
Guest Lecture: Current Concepts in Refractive Surgery
Richard Lindstrom, M.D.

11:40
Discussion

12:00NOON
Current Usage of Oculinum in Ophthalmology
Zane Pollard, M.D.

12:10PM
Standardized Clinical Electroretinography
Scott R. Lambert, M.D.

12:20
Management of Stage III and IV Retinopathy of Prematurity
Paul Sternberg Jr., M.D.

12:30
Discussion

12:40
Luncheon

Session #3
Robert Summerer, M.D., Moderator

2:00PM
Diabetes 2000: Georgia 1990
William H. Jarrett II, M.D.

2:10
Subretinal Neovascularization in Children
Erin Booher, M.D.

2:20
Indirect Injuries of the Optic Nerve
Robert H. Spector, M.D.

2:30
Discussion

2:40
Selected Trade Secrets in Cornea and External Disease
Alan M. Kozarsky, M.D.

2:50
The Correction of Astigmatism Using Hyperopic Thermal Keratoplasty
Robert H. Marmer, M.D.

3:00
Management of Cataract in the Presence of Corneal Dystrophy
David S. Hull, M.D.

3:10
Discussion

3:20
Leber's Hereditary Optic Neuropathy: The Clinical Profile of a Mitochondrial DNA Mutation
Nancy J. Newman, M.D.

3:30
It's in the Bag or Safe Phaco
Charles K. Bradley, M.D.

3:40
Discussion

3:50
Adjourn

ORTHOPEDIC SURGERY

GEORGIA ORTHOPAEDIC SOCIETY

Sunday, November 18
Foot Surgery: What You Thought You Knew
Meeting—8:30AM-4:30PM
Luncheon—12:00-1:30PM

PROGRAM CHAIRS:

Lamar L. Fleming, M.D.
James E. Averett, Jr., M.D.
Judith W. Smith, M.D.

FACULTY:

Michael T. Coughlin, M.D.
Boise, Idaho

Roy W. Sanders, M.D.
Tampa, Florida

Michael E. Miller, M.D.
Associate Professor, Chief of Orthopaedic Service, Grady Memorial Hospital, Atlanta, Georgia

Michael M. Romash, M.D.
Sports Medicine and Orthopaedic Center, Inc., Chesapeake, Virginia

Judith W. Smith, M.D.
Assistant Professor, Department of Orthopaedics, Emory University School of Medicine, Atlanta, Georgia

Sunday

8:30AM
Welcome
James E. Averett, Jr., M.D.

8:35–9:05
Complications and Salvage of Bunion Surgery
Michael J. Coughlin, M.D.

9:05–9:10
Discussion

9:10–9:40
Jones Fractures
Judith W. Smith, M.D.

9:40–9:45
Discussion

9:45–10:15
Subluxation and Dislocation of the Second Toe
Michael J. Coughlin, M.D.

10:15–10:20
Discussion

10:20–10:40
Coffee Break

10:40–11:10
Metatarsal Osteotomies: Good or Bad?
Judith W. Smith, M.D.

11:10–11:15
Discussion

11:15–11:45
Sesamoid Abnormalities, Conservative and Surgical Treatment
Michael J. Coughlin, M.D.

11:45–12:00
Discussion of Above and Other Papers

12:00–1:30PM
Lunch

1:30–2:00
Classification of Calcaneal Fractures
Roy W. Sanders, M.D.

2:00–2:05
Discussion

2:05–2:35
Acute Care of Calcaneal Fractures: Opened and Closed
Michael M. Romash, M.D.

2:35–2:40
Discussion

2:40–3:10
Open Treatment of Calcaneal Fractures: Medium, Lateral, or Both
Michael E. Miller, M.D.

3:10–3:15
Discussion

3:15–3:45
Treatment of Malunited Calcaneal Fractures
Michael M. Romash, M.D.

3:45–3:50
Discussion

3:50–4:20
The Deadly Fractures: Type IV
Roy W. Sanders, M.D.

4:20–4:25
Discussion

4:25–4:30
Closing Remarks
Lamar L. Fleming, M.D.

OTOLARYNGOLOGY HEAD & NECK SURGERY

GEORGIA SOCIETY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY

GREATER ATLANTA OTOLARYNGOLOGY—HEAD AND NECK SURGERY SOCIETY

Friday, November 16

Meeting—9:00AM-3:15PM
Luncheon—12:15-2:00PM

PROGRAM CHAIRMEN:

Albert A. Clairmont, M.D.
Atlanta

William E. Silver., M.D.
Atlanta

Friday

9:00–9:15AM
Introduction
William E. Silver, M.D.

9:15–9:45
Transconjunctival Blepharoplasty
Wallace K. Dyer II, M.D.

9:45–10:30
Total Reconstruction of the External Ear
Mark M. Jones, M.D.

10:30–10:40
Coffee Break

10:40–11:10
Tympanoplasty in Otolaryngology in the 1990's
William Moretz, M.D.

11:10–11:40
Subglottal Stenosis in the Pediatric Patient
Raymond Schettino, M.D.

11:40–12:00
Thyroid Surgery
Nancy Griner, M.D.

12:15–2:00PM
Luncheon Program—Role of the Composite State Board of Medical Examiners and the Introduction to the National Practitioner Data Bank
Andrew Watry, Executive Director, Georgia Composite State Board of Medical Examiners

2:00–2:30
Diagnosis of Inner Ear Pathology
William Moretz, M.D.

2:30–3:00
Injections for Spastic Dysphonia
William Grist, M.D.
Gerald Gussack, M.D.

3:00–3:15
Conclusion
Albert A. Clairmont, M.D.

PATHOLOGY

GEORGIA ASSOCIATION OF PATHOLOGISTS
Saturday, November 17
8:00AM-6:00PM
ATLANTA SOCIETY OF PATHOLOGISTS
Sunday, November 18
9:00AM-3:00PM

Saturday

PROGRAM CHAIRMAN:

C. Robert Baisden, M.D.
Georgia Association of Pathologists

FACULTY:

James O'Quinn, M.D.
Augusta, Georgia

Saleh A. Zacki, M.D.
Atlanta, Georgia

Francis W. Chandler, Jr., Ph.D.
Medical College of Georgia School of Medicine

Peter Klacsman, M.D.
Augusta, Georgia

Dennis Padgett
Louisville, Kentucky

James R. Lyle
Augusta, Georgia

8:00–8:30AM
Welcome
C. Robert Baisden, M.D., President

8:30–9:30
Medical Examiners Bill
James O'Quinn, M.D.
Saleh A. Zacki, M.D.

9:45–12:00
Approach to the Pathologic—Diagnosis of Fungal Infections
Francis W. Chandler, Jr., Ph.D.

12:00–1:30PM
Lunch—On Your Own

1:30–3:00
Coding Workshop
Peter Klacsman, M.D., Moderator
Dennis Padgett
James R. Lyle

3:00–4:00
Business Meeting—Georgia Association of Pathologists

4:00–6:00
Reception—Sponsored by SmithKline Beecham Clinical Laboratories

Sunday

ANNUAL SLIDE SEMINAR
Atlanta Society of Pathologists
Surgical Neuropathology

PROGRAM CHAIRMAN:

Paul S. Fekete, M.D., President
Atlanta Society of Pathologists

Guest Speaker:
Bernd W. Scheithauer, M.D., Professor of Pathology
Mayo Graduate School of Medicine, Rochester, Minnesota

Presiding:
Paul S. Fekete, M.D., President
Atlanta Society of Pathologists

9:00–11:30AM
Morning Session

11:30–12:45
Lunch Break

12:45–3:00
Afternoon Session

PLASTIC SURGERY

GEORGIA SOCIETY OF PLASTIC SURGEONS
Saturday, November 17
Meeting—9:00AM-1:00PM
Luncheon—1:00-2:00PM

PROGRAM CHAIRMAN:

W. Jefferson Pendergrast, Jr., M.D., Atlanta

GUEST SPEAKER:

Stanley A. Klatsky, M.D., F.A.C.S., Assistant Professor of Plastic Surgery, Johns Hopkins University Hospital; Chief of Division of Plastic Surgery, Baltimore County General Hospital; Traveling Professor, The American Society for

Aesthetic Plastic Surgery, Inc., Baltimore, Maryland

Saturday Morning

9:00AM–1:00PM
Facial Aesthetic Surgery—A Creative or Restorative Operation
Stanley A. Klatsky, M.D.

11:00–11:25
Coffee Break

1:00
Luncheon and Business Meeting for Georgia Society of Plastic Surgeons

PSYCHIATRY

GEORGIA PSYCHIATRIC PHYSICIANS ASSOCIATION

Friday, November 16

Meeting—8:30AM-5:00PM
Luncheon—12:30PM-2:00PM

PSYCHOPHARMACOLOGY: A New Generation of Treatments

PROGRAM CHAIRMAN:

Philip T. Ninan, M.D., Associate Professor of Psychiatry, Emory University School of Medicine, Atlanta, Georgia

SPEAKERS:

Dwight Bearden, M.D., Assistant Professor of Psychiatry, Mercer University School of Medicine, Macon, Georgia

John Kane, M.D. Professor and Chairman, Long Island Jewish Hillside Medical Center, Glen Oaks, New York

Teresa Pigott, M.D., Chief, Adult OCD Research Studies, National Institute of Mental Health, Bethesda, Maryland

Craig Risch, M.D., Professor of Psychiatry, Emory University School of Medicine, Atlanta, Georgia

8:00–8:30AM
Continental Breakfast

8:30–8:45
Welcome and Introduction
Philip Ninan, M.D.

8:45–9:45
Psychopharmacological Treatment of Obsessive Compulsive Disorder
Teresa Pigott, M.D.

9:45–10:30
Advances in the Treatment of Depression
Dwight Bearden, M.D.

10:30–10:45
Coffee Break

10:45–11:30
Advances in the Treatment of Mania
Craig Risch, M.D.

11:30–12:00
Panel Discussion: Advances in the Treatment of Anxiety and Affective Disorders

12:00–1:30
Luncheon

1:30–2:30
Basic and Clinical Mechanisms in Psychosis
John Kane, M.D.

2:30–2:45
Coffee Break

2:45–3:45
Advances in the Treatment of Psychosis
John Kane, M.D.

3:45–4:30
Clozaril: The Emory Experience
Craig Risch, M.D.

4:30–5:00
Panel Discussion: Advances in the Treatment of Psychotic Disorders

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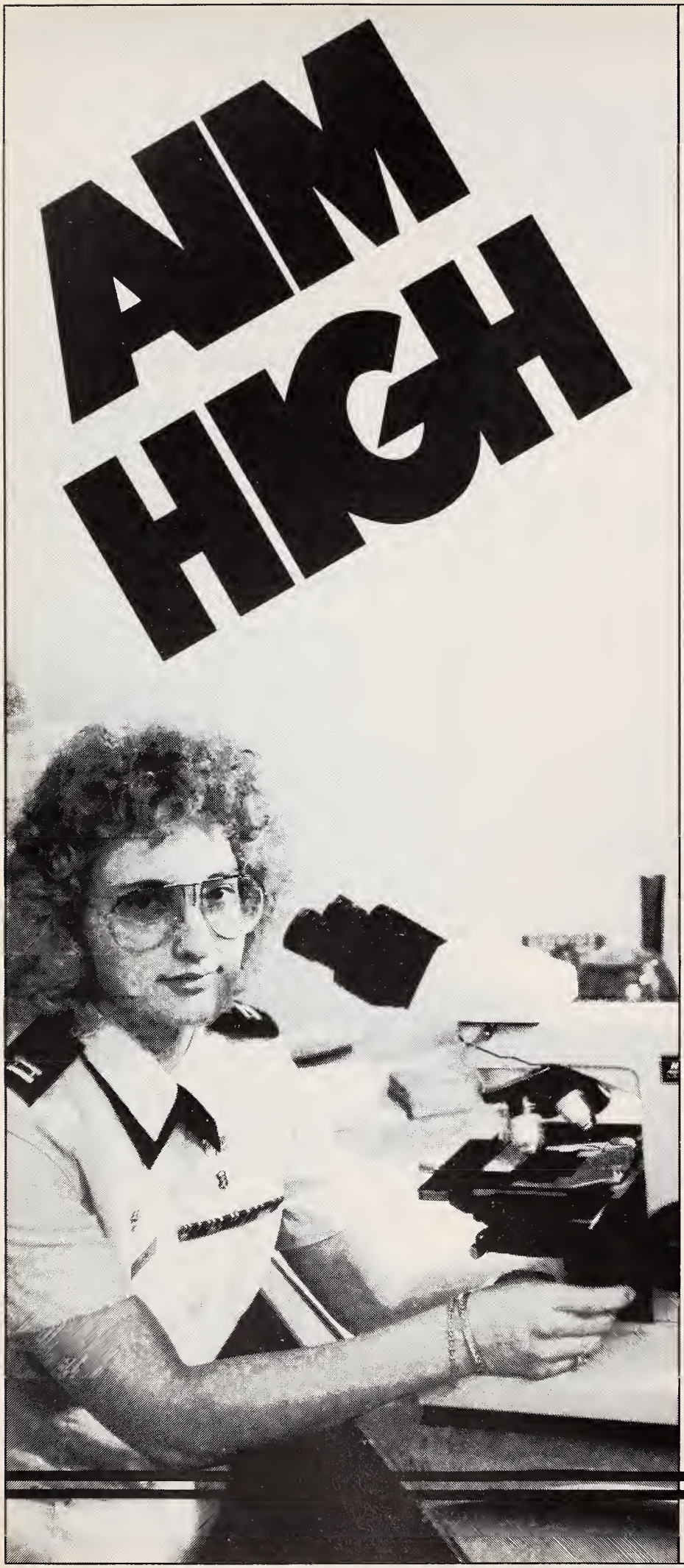

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AIR FORCE

The Evolving Role of Surgery in the Treatment of Breast Cancer

John P. Wei, M.D.

CARCINOMA OF THE BREAST is the most common malignant neoplasm in women today. The most recent statistics from the American Cancer Society show that there will be an estimated 150,000 new cases in 1990 and 44,000 women will die of the disease this year.[1] The prognosis of the cancer depends on the stage of the tumor at the time of diagnosis. The size of the breast tumor at initial presentation, the presence of lymph node involvement, and the presence of distant disease are determinants that affect the ultimate outcome and determine the therapy utilized. Breast cancer is currently staged by the TNM classification as set forth by the American Joint Committee on Cancer.[2]

Since the latter half of the nineteenth century, the approach to breast cancer has been that of a locoregional disease process. Halstead promoted the theory of the progressive and stepwise spread of tumor cells from the primary site to draining lymphatic basins. The eradication of breast cancer for cure was predicated on radical resection of the primary tumor of the breast along with the anatomic lymphatic regions at risk.[3] The radical mastectomy was the standard of treatment for breast cancer for many years. Some surgeons proposed more radical surgery such as the extended radical mastectomy with dissection of internal mammary lymph nodes in an attempt to improve the cure rate of breast cancer. The outcome of this radical surgery left the patient with marked disfigurement and with post-surgical complications such as lymphedema of the arm. Despite the radical surgery, some patients would develop recurrent cancer and die of it.

'The axillary dissection is not a curative resection of draining lymph node beds but is instead a staging procedure for prognosis and for determining requirements for adjuvant chemotherapy.'

Over the past few decades, improvements in the diagnosis and in the treatment of breast cancer have altered the theoretical approach to treating breast cancer. As effective screening and public awareness programs have come into existence, and as women are taught to do breast self-examinations, more breast cancers are being diagnosed at an earlier stage. The concept of radical surgery to extirpate breast cancer has been gradually replaced by that of conservative surgery. Clinical trials by the NSABP showed that the modified radical mastectomy was equal in results to that of the traditional Halstead radical mastectomy.[4] With the demonstration of the efficacy of radiation adjuvants in the treatment of breast cancer, the management of early stage breast tumors has undergone dramatic change. Stage I and II breast cancers (tumor, node, metastasis classification T1, T2, N0, N1, M0) which are smaller than 4 cm in diameter can be treated by breast conservation surgical techniques, i.e., lumpectomy, axillary dissection, and breast irradiation, with prognosis and survival equal to that of the modified radical mastectomy.[5] Recently, the criteria for selecting breast conservation surgery has been further refined to optimize the treatment of early stage breast cancer. Certain relative contraindications have been set forth: multifocal histology, diffuse

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microcalcifications on mammography, or the presence of extensive intraductal component (EIC) on pathology.[6] By carefully choosing those patients who stand to benefit from conservative surgery, breast cancer patients are then offered the best therapy possible. Women with early stage breast cancer who meet the selection criteria can opt for breast conservation, while the remainder should be treated with the standard modified radical mastectomy.

'If adjuvant chemotherapy proves to be of value in lymph-node negative breast cancer patients, it is conceivable that at some time in the future, axillary lymph node dissection will no longer be necessary for certain patients.'

The advent of effective chemotherapy and of hormone-receptor blockade has changed the survival and natural outcome of breast cancer. Breast cancer is a systemic disease, and treatment for it is based upon that premise. From that perspective, surgical intervention is a diagnostic procedure and provides a limited cyto-reduction of the primary tumor only. The axillary dissection is not a curative resection of draining lymph node beds but is instead a staging procedure for prognosis and for determining requirements for adjuvant chemotherapy.

TABLE 1 — TNM CLASSIFICATION

Tumor characteristics (T)

TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Tis*	Carcinoma in situ: Intraductal carcinoma, lobular carcinoma in situ, or Paget's disease of the nipple with no tumor.
T1	Tumor 2 cm or less in greatest dimension
	T1a 0.5 cm or less in greatest dimension
	T1b More than 0.5 cm but not more than 1 cm in greatest dimension
	T1c More than 1 cm but not more than 2 cm in greatest dimension
T2	Tumor more than 2 cm but not more than 5 cm in greatest dimension
T3	Tumor more than 5 cm in greatest dimension
T4**	Tumor of any size with direct extension to chest wall or skin
	T4a Extension to chest wall
	T4b Edema (including peau d'orange) or ulceration of the skin of the breast or satellite skin nodules confined to the same breast
	T4c Both (T4a and T4b)
	T4d Inflammatory carcinoma

Regional lymph nodes (N)

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis to movable ipsilateral axillary lymph nodes
N2	Metastasis to ipsilateral axillary lymph nodes fixed to one another or to other structures
N3	Metastasis to ipsilateral internal mammary lymph nodes

Distant metastasis (M)

MX	Presence of distant metastasis cannot be assessed
M0	No distant metastasis
M1	Distant metastasis (includes metastasis to ipsilateral supraclavicular lymph nodes)

Stage grouping

Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage IIA	T0	N1	M0
	T1	N1	M0
	T2	N0	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
Stage IIIA	T0	N2	M0
	T1	N2	M0
	T2	N2	M0
	T3	N1, N2	M0
Stage IIIB	T4	Any N	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1

*Note: Paget's disease associated with a tumor is classified according to the size of the tumor.
**Note: Chest wall includes ribs, intercostal muscle, and serratus anterior muscle but not pectoral muscle.

Adjuvant chemotherapy is accepted standard therapy for lymph-node positive premenopausal patients and tamoxifen like-wise for the lymph-node positive postmenopausal patient, but if adjuvant chemotherapy proves to be of value in lymph-node negative breast cancer patients, it is conceivable that at some time in the future, axillary lymph node dissection will no longer be necessary for certain patients.

Currently, the controversy over chemotherapy for lymph-node negative patients has not been clearly resolved (despite the Clinical Alert from the NIH), and breast cancer patients will continue to require the appropriate surgical procedures to determine their staging nodal status.[7] In a different light, trials are presently underway to test the validity of neo-adjuvant chemotherapy regimens and radiation therapy as the exclusive locoregional treatment for breast cancer.[8] The early results show promise, with tumor shrinkage in 41% of patients treated and complete regression in 30% of patients treated, but no definite conclusion can yet be made regarding this mode of treatment of breast cancer without surgery.

Despite efforts by the American Cancer Society and public health officials to educate the lay public about the benefits of early cancer detection, there is still a segment of the population that either is not reached by those efforts or does not have access to medical care. These patients present with advanced breast lesions or with disseminated disease. What is the role of surgery in these patients? In the patient with disseminated disease, Stage IV, surgical intervention should be minimized to spare the patient the risks and morbidity of major surgery. Tumor biopsy to obtain a diagnosis and establish hormone-receptor status and biopsy to confirm distant metastases should be sufficient. The treatment of choice is that of systemic chemotherapy. Concurrent radiation therapy to the primary breast cancer can help in locally controlling the disease. In the presence of an ulcerating lesion, which acts as a nidus for infection and is a hygiene problem, the so-called "toilet mastectomy" has a role in preparing the patient for systemic chemotherapy.

In the patient with locally advanced breast cancer without distant metastases, attempted radical resection of the cancer is attended by poor results. Inflammatory breast carcinoma should only be biopsied for diagnosis and treated with chemotherapy and radiation. Locally advanced breast cancers, Stage IIIA and IIIB, i.e., tumor more than 5 cm in diameter, lymph nodes fixed to one another or to other structures, or tumor with extension to chest wall or skin, generally have a poor prognosis after mastectomy alone or after radiotherapy alone.[9] Primary chemotherapy with subsequent mastectomy and radiation treatment have yielded improved 5-year overall survival rates of 84% for Stage IIIA and 44% for Stage IIIB patients.[10]

Surgery in the treatment of breast cancer has undergone much change since the earliest attempts to radically excise the tumor. Recent advances and clinical trials involving chemotherapy and radiation therapy have shed light on the natural biology of breast cancer and on newer methods of treatment. Carcinoma of the breast is no longer considered as a locoregional phenomenon but instead as a systemic disease which cannot be cured by surgery alone. The treatment of breast cancer requires an understanding and acceptance of this concept and necessitates an integration of the three different modalities of chemotherapy, surgery, and radiation therapy in their proper roles according to the stage of the disease in the patient.

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QUOTES

One pain is lessen'd by another's anguish;
One desperate grief cures with another's languish.

SHAKESPEARE:
Romeo and Juliet, I, c. 1596

If all men defined "honorable" and "wise" alike there would be no debate on earth. As it is, each man defines these words for himself, and only the names remain unchanged.

EURIPUDES:
The Phoenissæ, c. 410 B.C.

The first advice of a woman is always the best.

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State Regulation of Abortion Upon Minors: The Supreme Court Permits Parental Notification Statutes

Lisa F. Harper

JANE, A PREGNANT, 16-year-old, unmarried girl, has come to the local abortion clinic for help. Denying the existence of the problem and feeling terrified at its prospects, Jane has waited until she is 8 weeks pregnant to seek help. In talking with the physician on duty, Dr. Smith, Jane states that she is not ready for the responsibility of child-bearing or rearing and further indicates that she wants an abortion, but is terrified of telling her parents.

"In *Hodgson v. Minnesota* and *Ohio v. Akron Center for Reproductive Health*, the U.S. Supreme Court held that the Minnesota and Ohio parental notification statutes at issue were constitutionally permissible."

Since the clinic is in a state which has enacted state laws such as the ones recently upheld by the United States Supreme Court, Dr. Smith informs Jane that he cannot perform the abortion, unless both of Jane's parents are notified or unless she obtains a waiver of that requirement. Jane states that her parents are divorced and her father lives out of the city. Dr. Smith tells Jane that he is required to make a "reasonably diligent" effort to notify both of Jane's parents, regardless of their marital state or child custody situation, unless Jane chooses the alternative judicial by-pass process or has been the victim of sexual abuse. Jane responds that her pregnancy was not the result of sexual abuse, and that her parents will probably say no, if notified. Dr. Smith replies that the decision is ultimately Jane's; that notification of her parents followed by a 48-hour waiting period is all that is required.

Jane responds that she needs time to think, and as she prepares to leave, Dr. Smith gently reminds her that she is already 8 weeks pregnant, and that the by-pass process could conceivably take as long as 3 weeks, which could put her very close to the end of the first trimester and pose additional health risks. Thus, he advises her to make a thoughtful, yet quick decision.

TWO RECENT DECISIONS of the United States Supreme Court have upheld state regulations requiring pre-abortion notification of a minor's parents. In *Hodgson v. Minnesota*[1] and *Ohio v. Akron Center for Reproductive Health*,[2] the Court held that the Minnesota and Ohio parental notification statutes at issue were constitutionally permissible. These pivotal cases — which unfortunately appear to provide little, if any, guidance on the proper way for physicians and attorneys to deal with abortion cases involving minors, such as the one described above — are the focus of this Legal Section article.

Overview of Past Abortion Decisions

The Court has wrestled with state regulation of a minor's right to abortion since its landmark 1973 abortion decision, *Roe v. Wade*.[3] Generally, the Court has faced two types of state regulations in this context: parental consent and parental notification statutes. Since *Roe*, the Court has had seven opportunities to consider these issues, including the two most recent decisions.[4]

Judicial analysis in these cases requires (i) a balancing of the burden placed upon the minor's rights by the state's attempt to protect its interests in the minors and their families, and (ii) a determination as to whether the law is narrowly drawn to further

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the state's interests. It is a paradoxical argument: the state has an interest in the preservation of its families and in encouraging parental involvement in the abortion decision; however, the family has a privacy interest in the familial decision process and in the raising of its children without government intrusion.

In 1976, the Court had its first opportunity to balance these issues in *Planned Parenthood v. Danforth*.[5] The *Danforth* Court held that the state could not give parents an arbitrary veto over a minor's decision to have an abortion; that is, the state could not absolutely require parental consent. In *Bellotti v. Baird*, the Court later qualified the *Danforth* holding by finding that the state could require parental consent after all, if it also provided a method for waiving the consent requirement.[6] Many of the cases since *Bellotti* have required the Court to review state regulation of abortion upon minors under the general guidelines developed in *Bellotti*.

Strong dissents, frequent concurrences, and plurality decisions have peppered the Supreme Court's abortion opinions over the years since *Roe*. It is understandable, and perhaps desirable, that the opinions of the Justices reflect the disparate views of the American public. However, from a legal perspective, splintered opinions and plurality decisions do not provide strong precedent upon which lower courts or state legislatures can rest easy. The problem is clearly demonstrated in *Hodgson*. The decision in *Hodgson* was reached by a plurality of two Justices. Ironically, Justice Stevens, writing for the plurality, also wrote a dissent. Four other separate opinions were written by Justices O'Connor, Marshall, Scalia, and Kennedy, which concurred in part and dissented in part. The *Akron* decision, although a majority opinion of six Justices, included a strong and emotional dissent by Justice Blackmun, in which Justices Brennan and Marshall joined. In both cases, the differing judicial views appear to be a result of the varied perspectives taken on whether the statutes should be reviewed in their best light in which there is no family dysfunction or whether the negative, practical effects upon a dysfunctional family should be the focus.

"In 1987, the Northern District Court of Georgia enjoined a parental notification statute, much like the statutes upheld in *Hodgson* and *Akron*, in *Planned Parenthood Assoc. of Atlanta v. Harris*."

Overview of Hodgson and Akron

The various analytical perspectives should be kept in mind when reviewing the major points of contention in the cases, which are: (i) two-parent notice, (ii) 48-hour post-notification waiting period, and (iii) adequacy of the judicial by-pass. Two-parent notification, in which the Minnesota parental notification statute requires the physician to contact both of the minor's parents, was the primary issue in *Hodgson*. The Minnesota statute gives no consideration to the marital state of the parents or custody agreements between the parents. The 48-hour waiting period, also considered in *Hodgson*, requires the minor to wait 48 hours after her parents have been notified to allow for parental consultation, before having the abortion. The Ohio statute in *Akron* provides the minor an alternative to parental notification; this is frequently termed a by-pass procedure. Although the Supreme Court has not mandated a particular form for the by-pass procedure, it usually is a court proceeding in which a minor is given the opportunity to convince a judge that waiver of the parental notification requirement is appropriate for her. These three issues are discussed in more depth below.

Two Parent Notification

In *Hodgson*, the two-parent notification issue was addressed in stages. The first stage dealt with the constitutionality of two-parent notification, absent a judicial by-pass alternative. Justices Stevens, O'Connor, Marshall, Blackmun, and Brennan agreed that the two-parent requirement, standing alone, was unconstitutionally burdensome. According to Justice Stevens, writing for the Court, two-parent notification is (i) likely to bring out abusive or violent actions in an already dysfunctional family, (ii) likely to keep the minor from telling either parent, when she is in fear of telling one, and (iii) likely to cause disruption to families in which the custodial parent and the minor have severed ties with the non-custodial parent and are now forced to re-initiate contact. In addition, the Court noted that the two-parent requirement was not narrowly drawn to further the

state's interest, as the state's interest in parental involvement in the abortion decision could be served by a one-parent notification statute.

The second stage of the two-parent notification issue addressed the effect of the by-pass procedure upon the constitutionality of the two-parent requirement. Justice O'Connor and four other Justices (Kennedy, Rehnquist, White, and Scalia) held that the burden placed upon the minor by the two-parent requirement was made constitutional through the by-pass procedure, since it eliminated the primary constitutional deficiency, i.e., an absolute limitation on the minor's right to an abortion.[7] Although Justice O'Connor's judgment of constitutionality was joined by four other Justices, the concurring Justices would have given the states even more latitude. Based upon the state's interest in the welfare of its pregnant minors and its interest in protecting *each* parent's rights to participate in child-rearing, the four other Justices, led by Justice Kennedy, would have held the two-parent notification requirement constitutional, with or without the judicial by-pass.

Justice Stevens vehemently dissented, believing that the by-pass procedure could not make constitutional what was otherwise unconstitutional. According to Justice Stevens:

When the parents are living together and have joint custody over the child, the state has no legitimate interest in the communication between father and mother about the child. Where the parents are divorced, the minor and/or custodial parent, and not a court, is in the best position to determine whether notifying the non-custodial parent would be in the child's best interest.[8]

Justices Marshall, Brennan, and Blackmun joined Justice Stevens in dissent. These three dissenters, however, questioned whether the state has a right to require parental notification at all and reiterated the point made in *Bellotti* that "[n]either the scope of a woman's privacy right nor the magnitude of a law's burden is diminished because a woman is a minor."[9]

"Although the *Hodgson* opinion was extremely splintered, there seems to be little danger of a future decision restricting the latitude given the states in the two recent rulings. Four members of the Court in *Hodgson* would have given the states even greater authority than the plurality."

Forty-Eight Hour Post-Notification Waiting Period

The Minnesota statute at issue in *Hodgson* includes a provision which requires the minor to wait 48 hours after parental notification to have the abortion. The Court has previously considered waiting periods in the abortion context, but not with respect to minors. In *Akron v. Akron Center for Reproductive Health,* the Court held that the provision requiring a woman to wait 24 hours after consultation with her doctor to have the abortion furthered no legitimate state interest, and thus was invalid.[10] However, with respect to a waiting period for minors, it seemed reasonable to the Court in *Hodgson* to require a post-notification waiting period in that context, since it allowed an opportunity for the parent to consult with the minor and the physician. Without the waiting period, the notification requirement could be seen as a mere formality.

The dissenters, Justices Marshall, Blackmun, and Brennan, once again looked at the potential harmful effects of the post-notification delay and found them unduly burdensome. According to the dissent, the waiting period, especially in combination with other practical delays such as scheduling factors, parental work commitments, and school requirements, increased the health risk to the minor and thus, could not be dismissed as a minimal burden upon her.

Adequacy of Judicial By-Pass Methods

The Reproductive Health Center in *Akron* challenged the Ohio by-pass procedures under the standards set forth by the Court in *Bellotti v. Baird*. Although the *Bellotti* court did not mandate that the alternative to parental consent be in any particular form, it did set general standards. The waiver procedure must allow the minor to prove that (i) she is mature enough to make the decision on her own, or (ii) it is in her best interest to have the abortion. Additionally, the process must assure the minor's anonymity and be conducted expeditiously.

The Health Center in *Akron* argued that the Ohio by-pass was not expeditious and did not

protect the minor's anonymity. The by-pass procedure, it fully utilized, could take approximately 3 weeks. Three weeks, said the challengers, added to the practical reality that minors historically do not learn of their pregnancies until late in the trimester, and thus increased the health risk to the minor, unconstitutionally burdening her right to an abortion. The majority disagreed, stating that the Court could not review a statute under its worst case, since " '[w]here fairly possible, the Court should construe a statute to avoid a danger of unconstitutionality.' "[11]

The Health Center also challenged the requirement that the minor sign certain complaint forms, as a lack of protection of her anonymity. Other states had allowed pseudonyms or initials to be used instead. However, because Ohio provides other safeguards by specifically requiring that hearings and appeals procedures preserve anonymity and making it a criminal offense for the disclosure of confidential documents by state employees, a majority of the Court felt that adequate protection of the minor's anonymity was provided. According to this majority, adequate protection of anonymity did not require "complete anonymity."[12] The dissent, however, looked to the dictionary definition of anonymous and found that "[c]omplete anonymity . . . appears to be the only kind of anonymity that a person could possibly have."[13]

In addition to the *Bellotti* factors, the Health Center argued that the by-pass procedure has a "chilling effect" on the minor's right to an abortion, as it discourages physicians from performing abortions.[14] The Ohio statute requires that the physician *personally* notify the parents. Previous Supreme Court decisions had invalidated provisions requiring that a physician personally inform a woman about the risk of an abortion.[15] However, the Court found a distinction between the skill needed to inform a woman of routine abortion risks and the superior ability of a physician required to interpret and use information received by a minor's parents, and upheld the provision.

Implications For Georgia

In 1987, the Northern District Court of Georgia enjoined a parental notification statute, much like the statutes upheld in *Hodgson* and *Akron*, in *Planned Parenthood Assoc. of Atlanta v. Harris*.[16] The statute required one-parent notification, but also provided for a judicial bypass to the notification requirement. Because the Georgia statute required a parent or other adult to accompany the minor to the abortion facility to verify notification, the district court held that the statute unconstitutionally burdened the minor's right to an abortion and enjoined its operation. The following year, the Georgia General Assembly amended the statute to allow a written statement from the parent as verification of notification and added additional anonymity and expedition requirements. The statute was again challenged.[17] This time the district court enjoined the statute because (1) documents requiring the minor's name, signature, etc. compromised her anonymity, (2) appointment of a guardian ad litem also compromised her anonymity, and (3) the combination of the 24 hour post-notification waiting period and a 48 hour constructive notice period unduly burdened the minor's rights.

The recent United States Supreme Court decisions in *Hodgson* and *Akron* may throw the issue of parental notification into the foreground for yet another legislative battle in the Georgia General Assembly. Legislators and interest groups will be examining the decisions for guidance in reconsidering and possibly redrafting Georgia's presently enjoined parental notification statute. Ultimately, however, it is up to our judicial system to decide the constitutionality of whatever plan the Georgia General Assembly devises.

Notes

1. _____ U.S._____, 58 U.S.L.W. 4957 (June 25, 1990).
2. _____ U.S._____, 58 U.S.L.W. 4979 (June 25, 1990).
3. 410 U.S. 113 (1973).
4. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); *Bellotti v. Baird*, 443 U.S. 622 (1979); *H.L. v. Matheson*, 450 U.S. 398 (1981); *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 462 U.S. 476 (1983); *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S 416 (1983). Until the Supreme Court decision handed down this summer, the Court had only considered one parental notification statute. *Matheson*, 450 U.S. 398 (1981). The *Matheson* Court upheld the Utah parental notification statue, but only as it applied to dependent, immature minors. *Id.*
5. 428 U.S. 52 (1976).
6. 443 U.S. 622 (1979).
7. Justice Scalia concurred, but continues to point out his view that abortion law is a legislative issue, not a judicial one. *Hodgson*, _____ U.S. _____, 58 U.S.L.W. 4973 (June 26, 1990).
8. *Id.* at 4967.
9. *Id.* at 4969 [citation omitted].
10. 462 U.S. 416 (1983).
11. *Akron*, _____ U.S. _____, 58 U.S.L.W. 4982 [quoting *Planned Parenthood Association of Kansas City, Missouri v. Ashcroft*, 462 U.S. 476, 493 (1983)].
12. *Id.* at 4982.
13. *Id.* at 4987.
14. *Id.* at 4988.
15. *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).
16. 670 F.Supp. 971 (N.D. Ga. 1987) (enjoining O.C.G.A. §§ 15-11-110 to 15-11-118).
17. *Planned Parenthood Assn. of Atlanta v. Harris*, 691 F.Supp. 1419 (N.D. Ga. 1988).

Smoking Cessation Strategies for the Cardiac Patient

Benjamin B. Okel, M.D.

"Smoking is a custome loathsome to the Eye, hateful to the Nose, harmful to the Braine, dangerous to the Lungs, and, in the black stinking Fumes thereof, nearest resembling the horrible Stygian Smoke of the Pit that is bottomless" — JAMES I OF ENGLAND[1]

Introduction

Even though various voices of authority have admonished smokers for over three and a half centuries, tobacco smoking remains a foremost cause of death and disability in America today. It adversely affects every system of the body and accounts for more than one of every six deaths among Americans. Smoking is the leading risk factor for pulmonary-circulatory disease. It is responsible for 21% of deaths from coronary heart disease, 18% of stroke deaths, and 82% of deaths from chronic obstructive pulmonary disease.[2]

Tobacco smoking is one of the three treatable major risk factors for coronary artery disease, but its exact mechanism in causing coronary atherosclerosis remains uncertain. Some possible mechanisms are increased platelet aggregability, coronary vasoconstriction, and hypoxemia due to carbon monoxide.[3] Tobacco smoking has been shown to decrease levels of serum high-density lipoprotein, but increase levels of other lipoproteins and of fibrinogen.[4] Unlike the situation in lung cancer, the heart risk due to smoking rapidly diminishes on cessation.

"Quitting smoking successfully depends more on the personal commitment and degree of addiction of the patient than on the method used."

Tobacco smoking is a preventable risk factor except for the fact that it is often a seemingly incurable addiction. The present climate is the classical "goodnews/badnews" predicament. Multiple social pressures are encouraging smoking cessation and most who have quit have done so without assistance.[5] It now remains the lot of the physician to contend with the "hard-core" addict. The recent words of a wise patient summarize the current situation, "Only kids, fools, and addicts are smoking these days".

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This article was prepared at the request of the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this Section should send them to Dr. Robert Schlant, Journal HEART Editor, Department of Medicine, Emory University School of Medicine, 69 Butler St., SE, Atlanta, GA 30303.

Many Methods But Few Long-Term Successes

Commerical methods to stop the tobacco habit have been promoted since the last century. In 1969, 1977, and 1987 Schwartz[6-8] wrote excellent reviews of the cessation programs reported in the scientific literature. The many interventional methods included lectures regarding the dangers of tobacco, counselling, psychotherapy, support groups, lobeline, amphetamines, tranquilizers, mecamylamine, nutritional programs, behavior modification, hypnotherapy, hydrotherapy, acupuncture, biofeedback, aversive conditioning with electric shock, rapid smoking and breathing of stale tobacco smoke, vivid films on smoking-related diseases, and live-in stop smoking programs. These reviews show that no single plan stands out as "best." Short-term quit rates for any method approach levels are as high as 100%. However, at 1-year follow ups, few studies have shown more than a 33% quit rate. Most are in the range of 10% to 33%. Success depends more on the personal commitment and degree of addiction of the subject than on the method used. Also, it is obvious that successful maintenance strategies are as

important as quitting methods in achieving long-term abstinence.

Some of the methods currently used are potentially risky to the cardiac patient. Mecamylamine acts as a nicotine receptor antagonist and reduces satisfaction from smoking. However, its ganglionic blocking effects cause orthostatic hypotension, ileus, and urinary retention. Aversion therapy using the rapid smoking method, though statistically promising, could be dangerous due to the high levels of nicotine and carbon monoxide induced. Likewise, nicotine gum is contraindicated during the immediate post myocardial infarction period, life-threatening arrhythmias, and severe angina pectoris.

A recent study[5] using data compiled from the 1986 Adult Use of Tobacco Survey showed that about 90% of successful quitters and 80% of unsuccessful quitters used individual methods of smoking cessation rather than any organized or assisted program. Most smokers who quit on their own used a "cold turkey" approach. Gradual reduction in number of cigarettes smoked was the successful method in less than 13% of those who quit successfully but tried by more than 40% of those who subsequently relapsed.

Enquire and Encourage

In some respects, the physician's most important role is that of giving the patient the impetus to attempt cessation. For the patient already under multiple social/job/family pressures to quit smoking, the physician's recommendation may be the final successful nudge. Professional medical advice carries high credibility. Fiore, et al[5] found that more than 70% of "winners" and those who had "won" but relapsed had been urged to quit by a doctor. Some studies have shown that even brief advice of 35 to 40 seconds resulted in quit rates of about 5% at 6 months.[9,10] Hence, it is important to ask all patients if they smoke and if so, cessation should be encouraged.

"The recent words of a wise patient summarize the current situation, "Only kids, fools, and addicts are smoking these days."

Either a carrot or stick approach— or both— may prove useful depending on the individual patient and the doctor-patient relationship. Remarks such as, "If you stop smoking, you'll live longer and spend less on health care," "Wouldn't you rather be the master than the slave?" and "Would you continue employment, a sport, or other activity that stands a one in six chance of killing you?" may be the magic trigger. However, the physician should be supportive and non-judgmental. He should also be a non-smoking role model.

The Cardiologist's Golden Chance

Serious medical illnesses such as pulmonary disease and cardiac disease are shown to have the highest long-term quit rates in Schwartz's 1987 review.[8] Patients with pulmonary disease had median 1-year quit rates of 31.5% and those with cardiac disease 37% to 43%. A series of 125 post-MI patients given "strong advice"[11] achieved a quit rate of 62% at 1 to 3-year follow ups. Thus, acute symptoms of coronary disease, pulmonary disease, and other tobacco-related illnesses offer a window of opportunity to encourage a patient's cessation.

Use of Tranquilizers

Tranquilizers appear to be of limited, if any, value. Short, uncontrolled studies using chlordiazepoxide and diazepam revealed little beneficial effect. A study by Schwartz and Dubitzky[12] showed only a 6% success rate at 1 year in 36 patients prescribed meprobamate. The anxiolytic agent buspirone may be of some help in diminishing anxiety and is used for such purpose in smoking cessation programs. However, there are no published studies to prove its benefit.

Use of Nicotine Gum

Based on the premise that nicotine is the critical chemical ingredient in smoking dependence, Swedish researchers developed nicotine gum as a substitute for smoking in 1973. Nicotine polacrilex or Nicorette has been marketed in England, Europe, Canada, and other countries since the early 1970s and in the United States since 1984. Multiple placebo-controlled trials have shown significant benefit in cessation of smoking, but 1-year cessation rates have varied greatly — from 10% to 49%.[8] The higher quit rates have been achieved in programs using adjunctive counselling and behavior modification.

Many patients discontinue the gum due to side effects such as hiccups, nausea, indigestion, and sore jaws. However, these effects can largely be eliminated if the patient is taught to correctly use the gum — i.e. slow chewing and periodic "parking" of the gum

against the buccal mucosa. Systemic absorption of the nicotine occurs almost entirely through the buccal mucosa. One of the most common mistakes is to prescribe Nicorettes in an effort to help the patient "cut down" — a practice contrary to all current recommendations.

For many, the long-term use of nicotine gum is an essential ingredient of their success. Over 6% are using gum at 1 year[12] and in one trial of 207 subjects, a fifth were using the gum after a year.[8] Hence, this continuing dependence seems analogous to methadone as a control of opiate addiction.

"The physician is in a unique position to initiate a patient's attempted cessation, reinforce a patient's resolve, and offer support during the endeavor."

Information in the Physicians' Desk Reference and on the drug insert sheet specifically contraindicates nicotine gum in patients during the immediate post myocardial infarction period, patients with life-threatening arrhythmias, and patients with severe or worsening angina pectoris. Nicotine levels obtained chewing the gum are significantly lower than during ad libitum smoking.[13] Nevertheless, Nicorette-users, and especially cardiac patients, should be warned against chewing the gum and continuing to smoke, in that very high systemic nicotine levels can be so attained. A useful practice is to post-date the initial prescription for gum to the day the patient promises to quit smoking.

In spite of its shortcomings and undesirable side effects, nicotine gum has become a useful adjunct and particularly worthwhile as a psychologic crutch for certain patients. For these individuals "Don't leave home without it" seems wise advice during the months following their discontinuation of smoking.

Use of Clonidine

Clonidine is an alpha-2 noradrenergic agonist developed as an antihypertensive agent. In the early 1970s, is was found to be useful in diminishing the withdrawal symptoms from morphine[14] and later from alcohol.[15] Pearce[16] suggested and tried clonidine to stop smoking in his own family in 1986. A randomized double-blind trial among 71 heavy smokers by Glassman[18] showed significant improvement in cessation rates among subjects taking clonidine, the average dose being 2.39mg/day. However, successes were confined mainly to women. Subsequent studies have reported conflicting results. Davison, et al[19] reported a trend toward stopping smoking in a placebo-controlled trial of 186 smokers. Trials using the transdermal patch (CATAPRES-TTS-1 or -2) found that chronic smokers were nearly three times as successful in stopping cigarettes at 3 and 6 months as those on placebo.[20] A study in a primary care setting by Franks, et al[21] showed no effect of oral clonidine on withdrawal symptoms or quit rates at 24 weeks.

Bothersome side effects such as dry mouth, drowsiness, and sedation are reported in all studies of clonidine and result in some dropouts.

Clonidine can be started as the initial agent to reduce craving in patients who are decreasing heavy smoking. Later nicotine gum can be added on the patient's promised "quit day."

"Slips are to be expected. It is common for several cycles of quitting and relapse to precede successful cessation."

Self-Help Booklets

At little or no cost, excellent self-help kits and booklets are available from the American Lung Association, the American Heart Association, the American Cancer Society, the National Cancer Institute, and other organizations. These emphasize stopping hints, behavior modification, and coping strategies to maintain the tobacco-free state.

The Long Battle

The maintenance of the non-smoking state is as important as the act of quitting. Often the doctor-patient relationship ensures long-term follow up and an added incentive for the patient to maintain abstinence. The primary care physician has a uniquely favorable position in monitoring long-term follow up.

Many obstacles to permanent success can be expected to arise, and the patient needs to be prepared to meet them. He/she should be psychologically braced to cope with crises in manners other than smoking. The aforementioned self-help books give useful tips in controlling the

many cues that prompt smoking. Keeping nicotine gum handy over the long term can serve as a psychologic lifeboat. Slips are to expected. It is common for several cycles of quitting and relapse to precede successful cessation. The physician should encourage rather than admonish.

Weight gain is a common problem and often is given as a reason to resume smoking. A regular exercise program and discretion in avoiding high calorie foods should be encouraged. However, the added stress of a formal weight reduction diet should be avoided. Many highly addicted smokers suffer depression. Glassman[18] found in his series of 71 heavy smokers a 61% incidence of depression. The antidepressant fluoxetine (Prozac), with its lessened tendency to cause weight gain, would be a logical adjunct to management of depressed smokers attempting to quit.

Summary and Conclusions

Studies involving subjects attempting to discontinue cigarette smoking reveal that long-term success rates remain disappointingly low — in the range of 10 to 33 percent at 1 year. No single method or drug has proved to be a panacea. Serious commitment by the patient is of paramount importance in achieving long-term success. The physician is in a unique position to initiate a patient's attempted cessation, reinforce a patient's resolve, and offer support during the endeavor. Clonidine appears to decrease craving and nicotine gum decreases withdrawal symptoms in many patients.

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QUOTES

Oh, that my tounge were in the thunder's mouth!
Then with a passion would I shake the world.

SHAKESPEARE:
King John III, c. 1596

We went to Mannheim and attended a shivaree — otherwise an opera — the one called "Lohengrin." The banging and slamming and booming and crashing were something beyond belief.

S. C. CLEMENS (MARK TWAIN):
A Tramp Abroad, IX, 1879

In vain the sage, with retrospective eye,
Would from th' apparent what conclude the why,
Infer the motive from the deed, and show
That what we chanced was what we meant to do.

ALEXANDER POPE
Moral Essays, I (Of the Knowledge and Characters of Men), 1733

Nature never intended man to be a low, grovelling creature. From the moment of his birth she implants in him an inextinguishable love for the noble and the good.

LONGINUS:
On the Sublime, XXV, c. 250

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MRI UPDATE

Figure 1

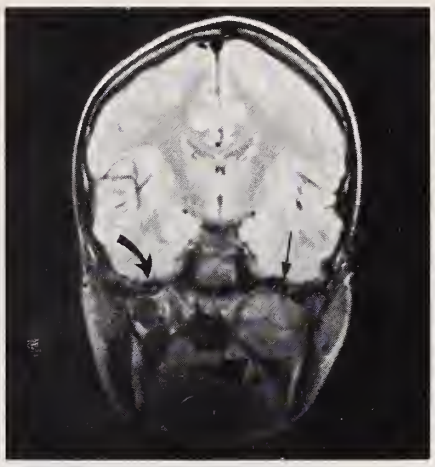

Figure 2

CLINICAL INFORMATION: This is a 14-year-old male with headache and left jaw pain.

FINDINGS: The axial image (figure 1) demonstrates a 4 cm. mass centered in the left parapharyngeal space. It deforms the left nasopharyngeal wall, but the fat plane between the nasopharyngeal wall and the mass indicates that the mass did not arise from epithelium there. The mass extends anteriorly through the pterygopalatine fossa to abut the posterior wall of the maxillary sinus (arrowhead), but it does not appear to invade the sinus. The mass extends laterally adjacent to the neck of the mandibular condyle (large arrow). It is separated from the deep lobe of the parotid by the deep branch of the facial artery. The mass is separated by fat from the internal jugular vein (open arrow). It abuts, but does not encase the internal carotid artery (long arrow). The coronal image (figure 2) demonstrates the mass effect of this large lesion (large arrow). Though the mass lies adjacent to the foramen ovale (small arrow) and appears to engulf an exiting branch of the mandibular nerve, it does not extend intracranially. The mandibular division of the fifth nerve lying just above the foramen ovale is shown on the normal right side (curved arrow).

COMMENT: MRI clearly demonstrates the size and extent of the mass in this difficult location. CT does not provide the multiplanar capability and soft tissue detail afforded by MRI which provides complete presurgical staging and analysis. The differential diagnostic possibilities must include juvenile angiofibroma because of the patient's age and sex. Paraganglioma and schwannoma were also considered possibilities. Mixed tumor arising from the deep lobe of the parotid could produce this appearance, but the lesion appeared to be separate from the deep lobe. The biopsy diagnosis was "sarcoma". Rhabdomyosarcoma in this area more commonly occurs in younger children.

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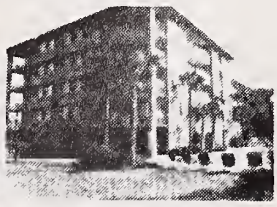

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MANUSCRIPT INFORMATION

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged.

STYLE — In general, articles can be 8-10 pages in length. For exceptional circumstances, contact the Managing Editor. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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NOVEMBER 1990

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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The Ethical Dilemma: To Do or Not To Do

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THE COVER

The painting on the cover by New York artist Robert Jessup is entitled "The Mad Puppeteer as Hamlet." Hamlet's questions about life, to be or not to be, are reminiscent of the ethical dilemmas facing today's physicians. Read more about this art and artist on page 799.

AMERICAN MEDICAL ASSOCIATION

Interactions
A Medical Staff Leadership Program

November 29, 1990
The Peabody Orlando
Orlando, Florida

Medical staff leaders may find that their special clinical skills and extensive clinical experience do little to prepare them for the complexities of this demanding role. A role that requires the skills and sensitivity of an arbitrator, facilitator, manager, advisor, negotiator, communicator, problem solver, peacemaker and professional peer.

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Program Participants
If you are a new chief-of-staff, department director, committee chairman or you serve in any other leadership capacity, the AMA's new Interactions can provide you with the self-assurance and skills you need to be successful in this challenging new role.

Leadership Objectives
- Improve emerging medical staff leaders' understanding of skills needed to perform formal duties.
- Enhance the understanding of medical staff leadership conflicts inherent in today's healthcare scene.
- Increase ability to interact effectively with medical staff peers and hospital/governing body leadership.

Location and Date
The AMA Medical Staff Leadership Program will be conducted on Thursday, November 29, 1990, at the Peabody Orlando Hotel, in Orlando, Florida. For ease of accommodations and travel, the AMA offers the program one day prior to the 1990 Hospital Medical Staff Section Interim Meeting, and three days prior to the 1990 AMA Interim Meeting.

Registration
For immediate registration or information, **call toll-free 1-800-621-8335.** Please have your MasterCard or Visa ready.

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Non-member - $375

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Stonewalling — Good or Bad

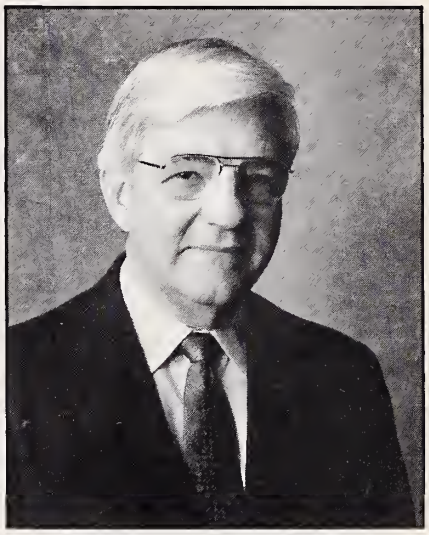
THE RECENT SERIES on the Public Broadcasting System concerning the Civil War is perhaps one of the finest documentary programs I have ever seen on television. Being a long-time student of what I was brought up to call the War Between the States, or the War of Northern Aggression, this has whetted my interest to do some deeper reading into the times and lives of the famous and not so famous wearers of BLUE and GRAY.

In reading again how my childhood hero, Stonewall Jackson, acquired his sobriquet or nickname, I have found numerous references to how Brigadier General Barnard Bee from South Carolina, in what is the usual story, tried to rally his troops by pointing out to them, "Rally 'round me, boys. Look at Jackson's brigade — there it stands like a stone wall." This was an obvious laudatory remark indicating that in a sea of swirling troops back and forth along the battle line, Jackson, in his holding of Henry House Hill in the first Battle of Manassas or Bull Run, was an exemplary commander as his troops stabilized an otherwise shifting Confederate line. It was an example for others to look to. The name took. Thereafter, and for all times, Thomas J. Jackson was referred to as Stonewall.

Through the years, therefore, I had always had this idea that perhaps sometime in my life I could be viewed by my contemporaries as having the qualities that I applied to this nickname, that is, being a steady and cool hand when everyone else was swirling in uncertainty; a bastion of virtue holding forth in a sea of immorality; or a champion of the established or conservative view when the torrent of socialism seems to be flooding the country. I have never had the opportunity to exhibit these sterling qualities to the degree that I had hoped in my childhood, but always in the back of my mind, there might come a time. . . .

For the sake of historical completeness, I must report that I have come across a couple of historians who have questioned the intent of Colonel Bee's statement. Some have suggested that those who heard him utter these words took them out of context, that he was really complaining that while his and other Confederate troops were being mauled on either side of Henry Hill, Jackson and his brigade stayed on the hill like a *stone wall,* whereas, they should have rushed to help their embattled comrades on either side of the hill. Contemporary historians never had an opportunity to query Colonel Bee on this point, as he succumbed to a mortal wound later on in that hot July day of 1861 that marked the first of the many major conflicts of our nation's greatest trial.

The second interpretation, if true, gives an entirely different meaning to the term Stonewall. In the question of Jackson, his subsequent stalwartness and success certainly made the first meaning appropriate. However,



William C. Collins, M.D.

Colonel Bee's intent certainly might have indicated that there could be other aspects to the term Stonewall. If we interpret it as being someone who is solidly fixed in his position and will not move for either the sake of his comrades or to make the general picture brighter, then I would certainly hope that no one has ever accused me of "Stonewalling it."

To put these together in what I would hope would be an appropriate connotation, I would urge us all to seek to be Stonewalls if, indeed, the name implies that our ideas or our positions in medicine are appropriate, just, and good for the health of the American people and for the success of our great country and we stand steadfastly for them.

If, however, we see the need for change in our health care system and we stubbornly refuse to work for these changes or actively oppose needed changes, then being a Stonewall might not be such a good thing!

Here again, only history will tell, but Stonewall Collins does have kind of a nice ring!

NEW MEMBERS

Ball, Joseph W., Psychiatry — Glynn — (Active) 300 Main Street, #202, St. Simons Island, 31522

Blevens, Kim T., Pediatrics — Peachbelt — (Active) 1165 Houston Road, Warner Robinis, 31088

Canning, Suzanne B., Psychiatry — Crawford W. Long — (Active) 1090 South Milledge, Athens 30605

Castro, Timothy, Jr., Anesthesiology — Tift — (Active) 1610 John Orr Drive, Tifton 31794

Christie, Jennetta M., Family Practice — South Georgia — P.O. Box 3841, Valdosta 31602

Fishman, Michael L., (Resident) 1001 Vinings Parkway, Smyrna 31499

George, John P., Orthopaedics — Georgia Medical — (Active) 11706 Mercy Blvd., Savannah 31499

Gumer, Arthur, Obstetrics/Gynecology — MAA — (Active) 5675 Peachtee Dunwoody Rd., Suite 730-D, Atlanta 30342

Hellwege, Michael A., General/Vascular Surgery — Peachbelt — (Active) 1701 Watson Blvd., Warner Robins 31093

Justice, Alan D., Internal Medicine — Georgia Medical — (Resident) Memorial Medical Center, P.O. Box 23089, Savannah 31403

King, Glenn R., Family Practice — Floyd-Polk-Chattooga — (Active) 530 Hunter Street, Rockmart 30153

Krendel, David A., Neurology — MAA — (Active) 1365 Clifton Road, N.E., Atlanta 30322

Lassiter, Homer L., Jr., Family Practice — Southwest Georgia — (Active) 142 Highland Avenue South, Arlington 31713

McGann, William F., Jr., Pulmonary Diseases/Internal Medicine — (Active) 601-A Professional Drive, Lawrenceville 30245

Naguszewski, Robert K., Internal Medicine/Neurology — Floyd-Polk Chattooga — (Active) 1825 Martha Berry Blvd., Rome 30161

Patterson-Barnett, C. Anne, Obstetrics/Gynecology — MAA — (Active) 5675 Peachtree Dunwoody Rd., Suite 730-D, Atlanta 30342

Pearson, Vincent D., Cardiology/Nuclear Medicine — Floyd-Polk-Chattooga — (Active) 1825 Marha Berry Blvd, Rome 30161

Phelts, Angus P., III, Otolaryngology — Mucsogee — (Active) Suite 204 Physicians Building, Columbus 31096

Schettino, Raymond L., Otolaryngology — MAA — (Active) 1580 Bakers Glen Drive, Atlanta 30350

Schottenfeld, Roy S., Otolaryngology — MAA — (Active) 11660 Alpharetta Highway, Suite 285, Roswell 30076

Sermonds, Alvin L., Obstetrics/Gynecology — MAA — (Active) 1829 Independence Square, Suite 1, Dunwoody 30338

Skaliy, Peter M., Anesthesiology — DeKalb — (Active) 2480 Empire Forest Drive, Tucker 30084

Tewes, Patricia A., Anesthesiology — MAA — (Active) 1984 Peachtree Rd., NW Suite 515, Atlanta 30309

Trentacosti, Ann Marie E., Internal Medicine — Cobb — (Active) 611 Campbell Hill Street, Suite 103, Marietta 30060

Trimble, John J., III, Otolaryngology — Floyd-Polk-Chattooga — (Active) 15 John Maddox Drive, Rome 30161

Walker, Charles A., General Surgery — Decatur-Seminole — (Active) P.O. Box 1805, Bainbridge 31717

PERSONALS

Bibb CMS

Atlanta pediatrician **Frank M. Houser, M.D.,** who has worked in public health to reduce infant mortality and fight adolescent drug abuse, is the new director for the 13-county East Central Health District. In 1974, Dr. Houser assumed the role of district health director for Georgia's Northwest Health District. Since 1980, he has been president and medical director of Southeastern Health Services Inc., which provides all medical services to 45,000 PruCare members in Atlanta.

Clayton-Fayette CMS

Jeffrey A. Kunkes, M.D., a Riverdale otolaryngologist-head and neck surgeon, was recently installed as president of the Georgia State Society of the Otolaryngology-Head & Neck Surgery.

Cobb CMS

Guy Sommers, M.D., of Lawrenceville, was recently elected to serve a 1-year term as

vice president of the medical staff at Ridgeview institute in Smyra. Dr. Sommers is an addictionologist in private practice at Ridgeview, specializing in the treatment of adolescent and young adults.

W. Theron McLarty, M.D., of Smyrna, was recently elected as president of the medical staff at Ridgeview Institute in Smyrna. Dr. McLarty is a board-certified psychiatrist in private practice and Program Director of Ridgeview's Adult Psychiatric Treatment Program.

Habersham CMS

David Bray, M.D., an internist practicing in Cornlia, has been elected chief of staff at Habersham County Medical Center, for a 1-year term.

Ogeeche River CMS

Claxton physician **Curtis G. Hames, M.D.,** has been granted an Award for Distinguished Achievement by *Modern Medicine,* a nationally circulated clinical journal for primary care physicians. He was among four recipients featured in their June issue.

Dr. Hames was recognized for this contribution to the understanding of genetics, immunology, cancer, hypertension, stroke, myocardial infarction, pesticide pollution, neurohormones, and psychosocial determinants of disease.

His current activities center on working to further a national network of primary care research centers that will eventually be linked to a world network, pushing for fundamental changes in the character of medical education, and developing a primary care clinic and research facility in Nigeria.

Richmond CMS

David L. Anders, M.D., of Fayetteville, has been appointed director of the Transitional Residency Training Program at Georgia Baptist Medical Center. Dr. Anders will coordinate the post graduate training of Georgia Baptist's medical doctors.

DEATHS

Y. Franklin Carter, Jr., M.D., of Nashville, GA, died of cancer last September. He was 63.

Dr. Carter, who retired from his medical practice April 1, was a leader in the move to build the Berrien County Hospital in 1965. He was a member of the Composite State Board of Medical Examiners for 13 years.

He graduated from Gordon Military College, Emory University, and the Medical College of Georgia.

Dr. Carter served in the Navy in World War II. He was a former Nashville mayor and councilman.

John E. Gregory, M.D.

John E. Gregory, M.D., of Columbus, died last June at the age of 81.

Dr. Gregory received his B.S. degree from Mercer University in Macon, and his masters degree in physiological chemistry and medical degree from the University of Cincinnati. He was a member of Alpha Omega Alpha Medical Honor Society and a former resident and assistant pathologist at Johns Hopkins Hospital and University, Baltimore, MD.

Ernest G. Smith, Jr., M.D.

Ernest G. Smith, Jr., M.D., of Atlanta, a retired radiologist from Atlanta, died last July of respiratory failure. He was 72.

Dr. Smith practiced medicine in Atlanta from 1951 to 1983. He was the former head of the radiology department of Piedmont Hospital, and he became the acting director of the department of nuclear medicine at Grady Memorial Hospital in 1967. He was one of the first physicians in the Southeast to practice nuclear medicine. He was also director of nuclear medicine at Crawford W. Long Hospital from 1969 until his retirement in 1983.

Dr. Smith graduated from Harvard University and the Johns Hopkins University School of Medicine. He interned at the Johns Hopkins University Hospital and completed his residency at University of Virginia Hospital.

During World War II, he served in the Army Medical Corps.

Dr. Smith was named a fellow of the American College of Radiology in 1973. He was a former president of the Atlanta Radiological Society and the Eastern Radiological Society and an instructor and associate professor of radiology at the Emory University School of Medicine from 1952 until 1982.

QUOTE

Our sex's weakness you expose and blame,
Of every prating fop the common theme;
Yet from this weakness you suppose is due
Sublimer virtue than your Cato knew.
From whence is this unjust distinction shown?
Are we not formed with passions like your own?
Nature with equal fire our souls endued:
Our minds as lofty, and as warm as our blood.

MARY WORTLEY MONTAGU:
Letter to James Steuart, July 19, 1759

Task Force to Examine Biomedical Ethics

The College of Chaplains, Schaumburg, IL, recently formed a task force to explore the critical role hospital chaplains play in biomedical ethics issues. The 10-member group is charged with "identifying and addressing biomedical ethics issues facing hospitals, particularly as they relate to spiritual values."

During the college's annual meeting in Nashville, TN, the chaplains expressed a need to make a contribution within hospitals by presenting a pastoral view that encompasses human and religious values. Among the resolutions adopted by the college's board regarding advanced care directives and medical ethics issues is one stating that it is necessary for a hospital ethics committee to include a chaplain and representatives of other religious faith groups, as well as health care professionals.

National Nurse Vacancy Rate is 12.6 Percent

The national vacancy rate for full-time hospital registered nurses rose to 12.66 percent as of April, 1989, according to American Hospital Association survey data.

Considerable differences in RN vacancy rates were found among 10 regions of the country, according to the AHA 1989 Nursing Personnel Survey. Vacancy rates at 920 responding hospitals ranged from a high of 17.46 percent in the South Atlantic region to a low of 8.15 percent in the West North Central region. Other regions with high RN vacancy rates included the Mid-Atlantic (13.88 percent), the West South Central (13.32 percent), the East South Central (11.57 percent), and the Pacific (10.98 percent).

The 1989 survey data also showed that:

- 18.4 percent gave bonuses to newly hired RNs, and 7.4 percent offered bonuses for continued employment;
- 46.5 percent offered RNs a permanent shift choice;
- 66.4 percent offered cross-training for floating RNs;
- 76.7 percent provided tuition assistance to licensed practical nurses enrolled in RN programs; and,
- 26.2 percent had physician/RN collaborative practice committees.

Concensus Sought on Medical Auditing Guides

The American Hospital Association stands ready to work with other health care groups in developing guidelines for auditing medical bills, according to AHA President Carol McCarthy. She said the association will raise the issue with the Health Insurance Association of America (HIAA), Washington, DC, and the Chicago-based Blue Cross and Blue Shield Association. The AHA comments came in response to a request from Sen. William V. Roth Jr. (R-Del.) to help develop voluntary guidelines to ensure that auditors remain impartial.

Hospitals usually pay revenue recovery firms a percentage of recovered medical charges. Similarly, insurers pay auditors a percentage of the amount by which they decrease hospital bills. But Roth introduced a bill to bar hospitals and insurers from offering financial incentives to medical auditors. The legislation would ban percentage-based payments, which Roth contends affect an auditor's impartial judgment.

Proposed Telephone Rule Could Cost Hospitals

Under a regulation proposed by the Federal Communications Commission (FCC), hospitals could be forced to make costly upgrades or to purchase new telecommunications equipment. The proposed rule is aimed at ensuring consumer access to competitive long-distance telephone rates. Under the proposal, a hospital's telephone carrier would be required to identify itself to callers, provide rate information, and allow callers to select another telephone carrier.

But the Healthcare Information and Management Systems Society (HIMSS), warned that the customer access routes required under the proposed rule would force many hospitals to make costly equipment changeovers. The rule "could very well hit hard at our industry at a time when hospitals are facing grave circumstances," HIMSS stated. To avoid such a blow to hospitals, the society asked the FCC to permit an alternate customer access route through hospitals' existing equipment.

Hospitals that fail to comply with the final rule could face a $10,000 fine for single violations and up to $75,000 in fines for continued violations, according to an FCC spokesman.

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References:
1. Data on file, G.D. Searle & Co. **2.** 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

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About the Artist: Robert Jessup

"Seldom does a painter work with the eye of a stonecutter and the touch of a pastry chef."

So has New York artist Robert Jessup been described whose solid images reflect a passion for the sculpture of Greece and Renaissance Italy. Solid, that is, until you approach the paintings more closely. Jessup creates a viscid multicolored surface of impasto strokes that build up to the thick, tactile quality of a stucco wall. The densely saturated paint shimmers sensually as a result of the heavy pigment saturation.

The painting on the cover of the issue of this *Journal*, "The Mad Puppeteer as Hamlet," reflects this characteristic quality of Jessup's work. It is the second in a series of four puppeteer paintings. The first in the series features St. Paul as the puppeteer. The third and fourth paintings feature Don Giovanni and Abraham, respectively. All of these paintings involve this central character, the puppeteer, acting on a stage of his own creation. The themes are largely philosophical and deal with aspects of the father/son relationship. The contrasting notions of fiction and reality permeate the visual effect.

The Puppeteer on the cover is surrounded by life and death, the living and the dead, both individually and in society. Hamlet holds a skull in one hand and the ghost of his father in the other. Other characters from the play featured include his mother and stepfather and Ophelia. The artist has assigned ultimate responsibility to the central figure, the individual, within the painting. In this way he uses fiction in art as a means of making sense of the world.

As in "real" life, the individual must accept full responsibility for his/her choices, not blaming the past, present, or imagined future. Similarly, the physician as a central character in the life and death drama he/she acts in must take sole responsibility for the ethical choices he/she makes. Physicians, too, are on a stage of their own creation.

Jessup's idea on visual perception are clearly rooted in Cubism, but he puts a few savage twists on that concept for fragmentation. Densely worked to the point of opulence, the surface of his paintings are tightly woven networks of daubing brushmarks reminiscent of Van Gogh. It is a lush style of applying paint, and Jessup's color sense is delicately sensual as well. His images are suffused with art historical references. Often, however, the mood of his work is without joy or humor — and conveys instead trepidation and eeriness.

Jessup has brought to his art a clear and unique vision of the way the world is: brightly colored, distorted by passion and happenstance, full of the debris of civilization. The effect in many of his images is at once clearly drawn and well composed, yet confusing as hell. Spatial distortions, irrational scale, and a pervasive atmosphere of leaden stillness effect a metaphysical aura. His work has a special ineffable quality, too, which invites quiet observation without interpretation.

While Jessup's work certainly has a dreamlike quality, it can also be regarded as a heightened way of observing reality, rather than an interpretation or representation of dreams. He can be included with other such visionary artists as Breughel, Blake, and more recently, Peter Gourfain — artists whose goals are clearly allegorical, yet each of whom expresses an individual visual philosophy of life. Jessup's outlook is both cheerful and bleak. He sees the herosim of human life but also its futility and the ultimate decay of all our arcane activities.

Mr. Jessup's works may be seen at Fay Gold Gallery, 247 Buckhead Ave., Atlanta, GA 30305; ph: 404-233-3843.

Of Ethics — Of Right and Wrong

"I swear by Apollo, the physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation: To reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required: to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

With purity and with holiness I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption: and further from the seduction of females and males, bond or free.

Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men at all times, but should I trespass and violate this oath, may the reverse be my lot."

THE OATH OF HIPPOCRATES

"It is only when the catastrophe matches the natural obscurity of our fate that even the best representative of the race is liable to lose his detachment. It is very obvious that on the arrival of the gentlemanly Mr. Jones, the single-minded Ricardo and the faithful Pedro, Heyst, the man of universal detachment, loses his mental self-possession, that fine attitude before the universally irremediable which wears the name of stoicism. It is all a matter of proportion. There should have been a remedy for that sort of thing. And yet there is no remedy. Behind this minute instance of life's hazards, Heyst sees the power of blind destiny. Besides, Heyst is his fine detachment had lost the habit of asserting himself. I don't mean the courage of self-assertion, either moral or physical, but the mere way of it, the trick of the thing, the readiness of mind and the turn of the hand that come without reflection and lead the man to excellence in life, in art, in crime, in virtue and for the matter of that, even in love. Thinking is the great enemy of perfection. The habit of profound reflection, I am compelled to say, is the most pernicious of all the habits formed by the civilized man."

Victory, JOSEPH CONRAD

"The physicians and surgeons should not suffer themselves to be restrained, by parsimonious considerations, from prescribing wine, and drugs even of high price, when required in diseases of extraordinary malignity and danger. The efficacy of every medicine is proportionate to its purity and goodness; and on the degree of these properties, caeteris paribus, both the cure of the sick, and the speediness of its accomplishment must depend. But when drugs of inferior quality are employed, it is requisite to administer them in larger doses, and to continue the use of them a longer period of time; circumstances which, probably, more than counterbalance any savings in their original price. If the case, however, were far

otherwise, no economy, of a fatal tendency, ought to be admitted into institutions, founded on principles of the purest beneficence, and which, in this age and country, when well conducted, can never want contributions adequate to their liberal support.... Whenever cases occur, attended with circumstances not heretofore observed, or in which the ordinary modes of practice have been attempted without success, it is for the public good, and in an especial degree advantageous to the poor (who, being the most numerous class of society, are the greatest beneficiaries of the healing art) that new remedies and new methods of chirurgical treatment should be devised. But in the accomplishment of this salutary purpose, the gentlemen of the faculty should be scrupulously and conscientiously governed by sound reason, just analogy, or well authenticated facts. And no such trials should be instituted, without a previous consultation of the physicians or surgeons, according to the nature of the case."

Medical Ethics,
THOMAS PERCIVAL, M.D. (1803)

"Where we desire to be informed, 'tis good to contest with men above ourselves; but to confirm and establish our opinions, 'tis best to argue with judgments below our own, that the frequent spoils and victories over their reasons, may settle in ourselves an esteem and confirmed opinion of our own. Every man is not a proper champion for truth, nor fit to take up the gauntlet in the cause of verity: many from the ignorance of these maxims, and an inconsiderate zeal for truth, have too rashly charged the troops of error, and remain as trophies unto the enemies of truth. A man may be in as just possession of truth as of a city, and yet be forced to surrender; 'tis therefore far better to enjoy her with peace, than to hazard her on a battle: if therefore there rise any doubts in my way, I do forget them, or at least defer them, till my better settled judgment, and more manly reason be able to resolve them; for I perceive every man's own reason is his best Oedipus, and will upon a reasonable truce, find a way to loose those bonds wherewith the subtleties of error have enchained our more flexible and tender judgments."

Religio Medici, SIR THOMAS BROWNE, KT.M.D. (1643)

IT IS SUCH a nebulous word, ethics. So antique. So motherly. So confining. At times so theological. It invades our lives at an early age as we test the limits of our freedom and the extent of our mother's patience. It pervades and quietly guides and confines our play in kindergarten to the degree that we feel as prisoners restricted by bars and walls vaguely seen and poorly understood. It follows us, relentlessly, into our teenage years, giving pause to life-conforming behavior and shackling the sexual drives which surge over us. And thus we come to adulthood. To womanhood and to manhood, with this heritage bolstering us and in its subtleness quietly guiding us. Guiding our play and our work. Thus we cry out, "Where is our freedom?"

And so it is that as physicians we find ourselves engaged in that most demanding of endeavors programmed from our childhood, confined by our youth and now overseen in our maturity by nebulous forces both within and without. We grind our way through medical school and training programs, absorbing the technical aspects of our lives only to take an oath devised in the cradle of civilization and addressing issues long since altered by the waves of social change and professional and political pragmatism. We are asked to take that oath and abide by it throughout our lives. In

serious deliberation we swear to it and in our heart of hearts we whisper, "as best I understand and as best I am able to." And yet, practical or not, confining or not, restrictive or not, we have chosen, in full freedom and consent, to pass our days asking as we arise each day those confining and restrictive questions, "Is it moral? Is it ethical? Is it right?"

I first learned of "right and wrong" in grade school. I had accepted with modest pride the invitation of the principal of our rural grade school to walk with a fellow third grade student to the post office in order to bring back the day's mail. On our way, we saw fit to molest, to disarrange, the workshop of a student we felt some childhood jealousy towards. We were discovered. A paddling followed and that followed by an encounter between mother and principal, itself one of the early explorations of the latitude given teachers in regards to corporal punishment. But I, the student, I had learned of trust and confidence. The framing of my ethics was on its way.

The years of professional development followed as the forming continued. A classmate said to me on one occasion, "I make office expenses by the people I entertain on the golf course." And I thought to myself, "Is there any other way to accomplish this?" At yet another time, yet another good friend offered me the "rare opportunity" to invest in a diagnostic imaging center located across the street from and in competition with the hospital which for many years had provided my work place, making available to me every necessity for which I asked in order to care for my patients. Once again I asked myself if our ethical constraints are not too restrictive.

"Our world, our patients, cry out for answers, and beyond esoteric discussions and answers, cry out for thoughtful and compassionate performance. We must not be evasive or self-serving. We must not be silent."

These aside, the matter of those characteristics of thought and action learned at our mother's knees came most forceably to my mind this past week as I visited one of my patients in a local nursing home. She lay there in her 85th year, a lady of light color, positioned upon her side and curled into that conformity of body whereby so many years before she had entered this world. Debridement of her several pressure ulcers proceeded with no apparent response from the all but lifeless body. The family member came by briefly every week or so the nurse told me. I looked at the feeding tube, her lifeline, dangling from her nose removing the last vestige of modesty and self esteem from the once proud and modest lady. I looked at that tube and felt the underpinnings of my ethics, of my morality, falter. I wondered to myself who in the name of decency or compassion or simple common sense had the right to take upon themselves the decision to prolong the life of an individual who simply cried out to be left alone. I wondered if the challenges would ever cease as one day my judgment was called in question by the local Medical Care Foundation and on another day when it was suggested that a medical record be altered to increase reimbursement for the hospital and yet again when a respected research scientist at my own medical school was found to have falsified his experimental results. Again, I cried out, "Where is right and wrong?"

We come to these present days culminating the Twentieth Century since those years when the bedrock of our ethical lives was lain down with technical capability unforeseen in those early days and yet with the clear vision of right and wrong we so

desperately need and desire befogged by not only the complexities of the issues presented to us but also by the frailty of our humanity. Do we have rights to engage in entrepreneurial activities which threaten the financial stability of a hospital upon the very survival of which depends the welfare of not only ourselves but our patients?

"I wondered to myself who in the name of decency or compassion or simple common sense had the right to take upon themselves the decision to prolong the life of an individual who simply cried out to be left alone."

And should we do so, can we with comfortable ease make treatment decisions with the same attention to need and honest evaluation as when not so encumbered? Is health and the provision of health care a right of us all or a luxury to be gained by effort and paid for by personal holdings? Is life the same for the hopelessly congenitally deformed newborn the same as life for the severely injured or ill but salvageable child? Is the termination of life a decision for the pregnant mother to make or does that decision rest jointly with the father? Does Society, the Courts, become a part of the answer? Do we as physicians matter here at all? And then, when the shadows of the twilight of out patients' lives fall over them, do we again retreat from the hard decisions, from the legal threats, place the feeding tube, prolong the torture of a life now over, and comfort ourselves with the thought, "I had no other choice?"

This time, this year 1990, pleads with us to take an interest in, to come to grips with, these many ethical problems with which our forefathers in medicine struggled. The experimental work has been done. The time now comes for hard, honest, compassionate analysis and then for action. Playing God, whoever or whatever that may be, you ask? Surely not, I say. Only to realize that we are the minds and the hands of whatever Divine Entity, be that theological or scientific or cosmic, controls our lives. Our world, our patients, cry out for answers, and beyond esoteric discussions and answers, cry out for thoughtful and compassionate performance. We must not be evasive or self-serving. We must not be silent.

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My Next Appointment

Excuse me, nurse. I'd like to make an appointment for
my next visit to the doctor.
He told me to come again at Thanksgiving.
Now he may have meant the Thursday after the third
Sunday in November. But because of the skill
of his hands and his devotion to the welfare of
his patients, I can now . . .

— walk without pain
— sit with my knees crossed
— put my socks on and tie my shoelaces
without aid
— pick up fallen pine cones
— change a car wheel
— and do a slow waltz or a fox trot
if the opportunity ever arises.

So, nurse, because I'm indeed thankful everyday, Thanksgiving
cannot only mean the Thursday after the third Sunday
in November, can it?
So, when's my next appointment?

F. G. Stephenson
Tifton, Georgia

Contributed by C. B. Gillespie, M.D. — Albany, Georgia

CALENDAR

DECEMBER

1 — *Atlanta:* **Suicide Prevention for Clinicians.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Road, Atlanta 30322. PH: 404/727-5695.

1-2 — *Atlanta:* **Regional Anesthesia: Surgery, Obstetrics & Pain.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

1-6 — *Atlanta:* **American Academy of Dermatology.** Category 1 credit. Contact AAD, 1567 Maple Avenue, P.O. Box 3116, Evanston, IL 60204-3116. PH: 312/869-3954.

3-5 — *Atlanta:* **Nuclear Medicine Update.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-7 — *Atlanta:* **Magnetic Resonance Imaging.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14 — *Atlanta:* **Glaucoma Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

1991

FEBRUARY

8-9 — *Atlanta:* **Pediatric Orthopaedic Seminar.** Contact Darlene Baugus, Scottish Rite Children's Medical Center, 1001 Johnson Ferry Road, N.E., Atlanta 30363. PH: 404/250-2138.

22-23 — *Atlanta:* **28th Annual Ophthalmology Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

MARCH

1-2 — *Augusta:* **Flexible Fiberoptic Sigmoidoscopy.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

11-16 — *Augusta:* **26th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

22-23 — *Augusta:* **Ophthalmology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, August 30912-1400. PH: 404/721-3967.

APRIL

17-19 — *Atlanta:* **Nutrition and Cancer.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-21 — *Augusta:* **Current Concepts in Carnitine Research.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

26-28 — *Augusta:* **Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

27-28 — *Augusta:* **Pathology Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

9-4 May — *Augusta:* **26th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

MAY

9-12 — *Atlanta:* **Second Conference on International Travel Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

JUNE

17-22 — *Augusta:* **22nd Annual Internal Medicine Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

21-23 — *Augusta:* **Daily Anesthetic Challenges.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

27-30 — *Augusta:* **Hematology and Oncology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

JULY

15-17 — *Augusta:* **Update in Gynecology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

18-20 — *Augusta:* **11th Annual Clinical Obstetrics.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

18-20 — *Augusta:* **Neurology for the Non-Neurologist.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

22-26 — *Augusta:* **13th Annual Critical Care Medicine.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

22-26 — *Augusta:* **Clinical Cardiology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

29-31 — *Augusta:* **14th Annual Pediatric Update.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

THE PLACE OF A GEM

The sea is a diamond
Flashing its borrowed fire
Back to the sun and stars,
Buffed of its grime of clouds and fogs and mists
By the cleansing rain
And polishing cloth of winds,—

Cool as the blue of its crystalline depths
And warm as the fire its facets flash,
The sea is a diamond,
Fixed in the setting of the earth,—
One stone in the necklace
Of the universe,
Hanging about the neck
Of God!

WHEN AUTUMN ARRIVES

When crickets haven't chirped as much
And, when the night is over,
There's just the smallest hint of frost
That glistens on the clover.

The wind is blowing cooler now
Across the garden border;
The sun is not as warm somehow,
And days are getting shorter.

The birds were flying south today;
I saw the sunlight on them
Before the clouds closed it away
And pulled the dark upon them!

The trees are turning red again,
I see with secret sorrow;
But I must go to bed again
And see them all tomorrow!

JOHN RANSOM LEWIS, M.D.

Dr. Lewis, a plastic surgeon in Atlanta, is Georgia's Poet Laureate.

LETTERS

Dear Editor,
The September issue of the *Journal* is the best one I've read. It would win a comparative contest with any medical association journal.

Thank you and your staff.

Sincerely,
Don L. Eyler, M.D.
Orthopedist
Salem, AL

Dear Editor,
I wanted to write you a brief note concerning the editorial which I reviewed in the August 90 *Journal*. As an individual who is a third generation physician and has been practicing medicine in this state for the last 15 years, as well as an individual who is close personal friends with several doctors who have served as the physician Board of Medical Examiners in various states, I would concur wholeheartedly with your recommendation about publication. This is an issue that has caused me great personal anguish for a number of years, not because of personal experience, but because of an issue which I feel every physician should take great offense at which is the lack of protection of constitutional rights here in this country. Many physicians are not aware of the fact that within this great country we have constitutional protection against unreasonable search and seizure and we have certain guarantees of pursuit of life and liberty and of our chosen careers. Courts in general have held that depriving an individual of his ability to work should be taken only under questions of protection of national security or under issues in which the person has committed a criminal act. One of the issues that has caused me great consternation has been that frequently the general public and or the local media takes the position that if a physician is accused of a certain act then automatically without trial, without an ability to appear before a jury, and without an ability to even have representation, that physician is deemed guilty and unacceptable for practicing his chosen profession. I know of no group within society which is as subjected to these actions and in fact recent review of actions taken by the State Medical Board, bring into question whether they in fact they are guaranteeing the constitutional rights and liberties that are provided for us. . . .

I might ask the general question, physicians in fact are questioned under several practice deviations such as in medical malpractice cases where they are required to answer questions under oath which are then later used in a civil court of law and after the case has been dispensed with then in fact the State Board of Medical Examiners takes further action against the physician. I would ask you in fact why are not physicians versed and advised of their constitutional rights to remain silent or that their statements may be used against them? If a person is advised of a crime that they have committed, the *Miranda* decision put forth by the Supreme Court requests that a person be read his rights and that he be advised that any statements he make may be used against him. I ask why then is it that the practice of agencies such as the State Board of Medical Examiners is to take statements made in civil court and use these statements to later bring up investigation of an individual as to the fitness of his license based on a civil practice act? I am curious as to why this issue has never been addressed through the legal department in the *Journal*. . . .

I would further like to mention to you a recent statement that was made by the Secretary of HHS at the federal level. The Secretary appeared before a congressional panel and made the statement that based on review of Federal Rules and Regulations that cases involving physicians could not be adequately prosecuted because the prosecuting bureaucrats were having to follow the same rules and regulations as criminal prosecutions. The Secretary advised the Federal Government that they wish to have a change in the rules made whereby a bureaucrat could simple make a determination as to a violation of the code without subsequently having his case be applied to the same federal standards for production of evidence and suitability of documentation. Once again I would ask you, Is this justice, and are we subjected to the same rules and regulations that would apply in a criminal trial?

I realize that our system of justice is not perfect, but that our constitutional liberties and our protection under the law I feel is being trampled upon by codes and rules that fall outside the jurisdiction of the Constitution. I further feel that many of the actions that the State Board is making is putting physicians in a situation of double jeopardy. Obviously, I am not advocating physicians take the side of felons,

nor do I wish to cast our lot in the eyes of the public with these persons. I feel that there are legitimate questions that need answering. There was even a recent meeting that our county medical society held with Dr. Collins who is the current President of the MAG. My statement to Dr. Collins was along these same lines, and that is concerning the issue of the recent Federal Health Practices Reporting Act which keeps a central information bank on physician practice patterns. I made Dr. Collins aware of the fact that if there were any other group of individuals other than physicians, that this type of central data bank would not even be allowable. Persons have more protection of a credit record than physicians do concerning information that I believe should be protected against further scrutiny, and indeed taxpayers under the IRS Act again face more protection than a physician does through the federal data bank. What is even more obnoxious is that physicians can have information inserted in their record at the federal data bank based on the statement of one person at a peer review organization, who can make a decision on a unilateral basis which is not a trial before a jury, at which evidence is presented and the individual has an opportunity to refute the evidence before a jury, but instead is the decision of one bureaucrat and this one decision by one person can effect the doctor's entire life and career.

I would close in asking you, is this justice and is this something that we as citizens of this country should allow ourselves to be subjected to? In closing, I am happy that you made the decision you made concerning the editorial. I hope that you take the time to read my letter in full and ask yourself whether some of these same things bother you. . . .

Perhaps, think about these things that I am writing you and allow other physicians such as myself a forum to express our ideas.

Sincerely,
Richard A. Stappenbeck, M.D
Neurologist, Riverdale

QUOTES

Although hard to define, loyalty is easy to detect. Let a worker be ever so brilliant, ever so brainy, ever so ambitious, if his employers know he is not loyal through and through, they will not for a moment consider promoting him to a position of great trust and responsibility, for disloyalty breeds distrust.

B.C. FORBES

If other people are going to talk, conversation becomes impossible.

JAMES MCNEILL WHISTLER

Much meat, much malady.

THOMAS FULLER: *Gnomologia, 1732*

Love is like an hourglass, with the heart filling up as the brain empties.

JULES RENARD

Men who pass most comfortably through the world are those who possess good digestions and hard hearts.

HARRIET MARTINEAU

Can it be true, what is so constantly affirmed, that there is no sex in souls? — I doubt it, I doubt it exceedingly.

S.T. COLERIDGE
Table Talk, June 24, 1827

To be seventy years young is sometimes far more cheerful and hopeful than to be forty years old.

O.W. HOLMES:
Letter to Julia Ward Howe on her seventieth birthday, May 27, 1889.

Patience is the best medicine.

JOHN FLORIO:
First Frutes, 1578

Apollo was held the god of physic, and sender of diseases. Both were originally the same trade, and still continue.

JONATHAN SWIFT:
Thoughts on Various subjects, 1706

Physic, for the most part, is nothing else but the substitute of exercise or temperance.

JOSEPH ADDISON:
the Spectator, Oct. 13, 1711

Love at first sight is only realizing an imagination that has always haunted us; or meeting with a face, or figure, or cast of expression in perfection that we have seen and admired in a less degree or in less favorable circumstances a hundred times before.

WILLIAM HAZLITT:
The Prose Album, 1829

Be what nature intended you for, and you will succeed; be anything else and you will be ten thousand times worse than nothing.

SYDNEY SMITH

Editorial Alert

Charles R. Underwood, M.D.

YOUR JOURNAL this month is a special issue on ethics. We look at that complex subject from the viewpoint of a great variety of individuals.

Edmund Pellegrino is a physician and the Director of the Center for the Advanced Study of Ethics at Georgetown University.

David Zachs is an attorney in Atlanta interested in health care matters.

Kathy Kinlaw is Associate Director of the Center for Ethics in Public Policy and the Professions at Emory.

John Shuttleworth in his middle years has become a psychology major at Kennesaw College in addition to his duties as president and CEO of a health care risk management consulting firm. He has an abiding interest in the problems presented by our aging population.

Jim Lowry is the hospital administrator of the Colquitt Medical Center in Moultrie, Georgia.

Drs. Bruce Whyte and Joe Wilber are Medical Epidemiologist and Medical Consultant, respectively, at Resources for the State of Georgia.

Betty Castellani is the Cancer Center Director and Assistant Chaplain at Dekalb Medical Center.

And then of course **Eugene Stead** was once the Chairman of the Department of Medicine at Emory, leaving there many years ago to spend the rest of his academic life on the faculty at Duke.

Jim Laney is the President of Emory University and more than that a theologian of high standing.

Eugene Patterson followed Ralph McGill as Editor of the *Atlanta Journal and Constitution* in 1960 and then in 1968 moved to Florida and became Editor of the *St. Petersburg Times*. He was an ardent advocate for Medicare in those volatile and inflammatory early sixties when that program was being developed.

Daniel Callahan is a physician running the Hastings Center in New York and one of the foremost spokesmen for the re-evaluation of the ethical world in which we live.

And of course **John Stone,** physician, poet and Dean of Admissions at Emory, established one of the first medical school disciplines in the study of ethical matters in the medical school curriculum.

This distinguished group of individuals have a lot to say that we all need to hear. ■

The Medical Ethics Program at Emory

John Stone, M.D.

RECENTLY, I've had the pleasure of sitting on a committee for the Business School at Emory University. Its charge was to recommend whether a program in ethics should be set up within the School. The questions that arose during our committee deliberations were almost precisely those I remember being raised 14 years ago when the School of Medicine, examining its own curriculum, formed a similar committee with a similar charge. The questions, then and now, are:

1. **Should** ethics be taught?
2. If so, **how** should ethics be taught?

A third related (and inevitable) question of the cynics among us is, "**Can** ethics be taught?" — which implies, of course, that such material is only learned passively, insensibly, by "role model," in a kind of ethical osmosis.

That medical school committee, during the late 1970s, was comprised of clinicians, theologians, a philosopher, and a sociologist. We agreed early on that such a course was definitely necessary. (For my part, I had the uneasy feeling that there were some medical students who would not have recognized certain kinds of ethical problems if they came face to face with them in the hall.)

At Emory, we teach the current course, called Human Values in Medicine, during the second year of medical school (it meets 2 hours a week during the Fall Semester). There are several elements that I consider especially important. First, the course is "case" oriented: We have confirmed for ourselves that nothing piques a medical student's interest quite so much as a "real case." Second, we are at pains to make sure the medical facts of the case, the clinical options, are well understood by the students. (This is assured by having superb clinicians present each case, one from their own clinical practice.) Third, many of the sessions, in addition to the clinician(s), are also taught by people with special interest in medical ethics: for example, Dr. James Laney, President of Emory University (and a Ph.D. in Ethics) regularly attends the session on AIDS (led by Dr. Jonas Shulman, a specialist in infectious diseases).

The topics have varied some over the years but we have now agreed on certain topics that we feel are imperative to cover with each class. They include: (1) a consideration of euthanasia; (2) utilization of scarce medical resources (e.g., heart transplants); (3) the special problems of the neonates; (4) abortions; (5) the case of the dying patient; (6) genetic screening; (7) teenage sexuality; and (8) staying sane in medicine.

"Residents, nurses, allied health personnel of all types, and physicians in practice are just a few of the many groups who are seeking ways to consider ethical issues in their own clinical arenas."

University Professor Jimmy Carter has been a special guest lecturer for this class for many years. President Carter's abiding personal interest in many aspects of preventive medicine and in international health have set the stage for many stimulating sessions with the sophomore class over the years.

Dr. Stone is Professor of Medicine (Cardiology), and Dean of Admissions, Emory University School of Medicine, 1440 Clifton Rd., NE, Atlanta, GA 30322.

What are we hoping to accomplish with such a class? Perhaps, most importantly, I should state what we're not hoping to accomplish: we're not hoping to change any student's ideas about the fundamental ethical issues of our time. Those ideas have been formed over time: all of us have wrestled at length with such difficult issues and arrived at our own opinions. No, the central aim is to make the student more aware that **not everyone feels the same as he/she does on these issues.** We hope to educate, then, not indoctrinate. There are legal implications inherent in many of these ethical questions, and we have a responsibility to see that this material is covered as well.

We feel we have made considerable progress in this important area over the past decade or so. But there is still much to be done. For example, we at Emory are vitally interested in assuring that medical students in the 3rd and 4th years of medical school have a chance to reconsider these important issues, perhaps in the form of regularly scheduled "ethical grand rounds." Moreover, residents, nurses, allied health personnel of all types, and physicians in practice are just a few of the many groups who are seeking ways to consider these issues in their own clinical arenas. Clearly, ethicists and clinicians with interests in the subject are going to be busier than ever as we begin the 1990s. ■

An Address on Ethics

James R. Lowry

"As I read Lincoln's Gettysburg Address, I found myself modifying his words to address the maze that has been created around medical ethics."

THIS PAST month I had the opportunity to visit our nation's capital. Among many sights that I visited, I found myself at the feet of Lincoln's Memorial staring at his Gettysburg Address. As I read the words that were written over 100 years ago, I found myself modifying his words, adapting them as they might be used today to lead us through the maze that has been created around medical ethics:

. . . .

Six years and four months ago, our fathers brought forth on this land a new health care program, conceived in competition and dedicated that the free market will create a more cost effective health delivery system.

Now we are engaged in a great professional struggle of medical ethics, testing whether self-referred patients, joint ventures, limited partnerships, discounted HMOs, market analyses, and T.V. advertisement will long endure.

We now come to a new decade of reflection and thought and the end of a century consecrated with the achievements of dedicated physicians and health-care professionals who gave their careers nobly with devotion so that the cause in which they believed will be advanced.

It is for us, the present, to direct our profession so that clinical opportunities will not detract nor dishonor the spirits of our heritage; but resolve that no conflict of interest nor financial gain will alter our advocacy to our patients.

But in a larger sense, we must rededicate ourselves to the great task of building a fair and equitable health care system conceived with access to all and dedicated to the proposition that all men and women shall be cared for equally . . . except Georgia graduates, for that is why God created veterinarians.

From the jukeboxes of south Georgia, a popular song rings out, "The fruits of the labor are greater than the pay." We all know this to be true, and someday soon the problem of unethical conduct will pass. ■

Mr. Lowry is Administrator, Colquitt Regional Medical Center, 3131 Thomasville Highway, P.O. Box 40, Moultrie, GA 31776.

"We must rededicate ourselves to the great task of building a fair and equitable health care system conceived with access to all and dedicated to the proposition that all men and women shall be cared for equally . . . except Georgia graduates, for that is why God created veterinarians."

Cognitive Brain Death: The Major Ethical Issue of Our Time

Eugene A. Stead, Jr., M.D.

THE MAJOR ETHICAL issue of our times centers on proper care for persons with cognitive impairment of a degree which prevents meaningful contact with their environment and other persons. One has only to sit in a nursing home and observe the number of persons tied in a wheel chair who are being fed by an attendant placing food in sagging mouths to appreciate that we care for our pets much better than we care for people.

Our society has defined complete cessation of brain function as brain death and allows harvesting of organs in the presence of continued heart beat and respiration. In the absence of established criteria for brain death, we deny that the person has died.

‘There comes a time for dying, and many of us believe that cognitive brain death signifies that time. Prevent pain but do nothing more.’

The ability to be aware of the present, to fear the future, to relate to ourselves and to others are the qualities that separate man from other creatures. Disease of the brain may make us lose these human qualities, and our injured brains may function at a level well below that of our pets. Much of the brain may still function but that portion that makes us human has died. How should we care for such persons? There comes a time for dying, and many of us believe that cognitive brain death signifies that time. Prevent pain but do nothing more.

I have left instructions to my own family how to care for me in case I suffer death of my brain which controls cognitive functions. They are to do nothing to correct conditions that I do not complain about. If I am unshaven, wear dirty clothes, soil my pants, stuff candy in my bureau drawers and ignore the ticks and mice — fine. If I wander and may fall — don't worry. Leave me be.

Don't immunize me, don't give me antibiotics when I have infections, don't feed me unless I want to eat. No tube feeding! No intravenouses! Leave me be!

A part of our problem is that we have not educated people about the death of the cognitive portion of the brain. When this partial brain death occurs we no longer need or require the amenities that we required when our brain was healthy.

Families go into nursing homes and are shocked to find that their cognitive brain dead relatives are not given care that they consider proper. We need to focus on what care benefits the patient with cognitive brain death and not what benefits the healthy relatives. Do we need to provide amenities for bodies whose brain no longer desires them? The question of how much care for whom is the major ethical issue of our times.

‘Do we need to provide amenities for bodies whose brain no longer desires them?’

I do not believe that we should attempt to establish laws that will regulate the care of persons with cognitive brain death. We need more education of patients by doctors and other professionals who are knowledgeable about loss of cognitive functions and the change in requirements for care of persons with cognitive brain death. We need more permissive approaches which allow families more freedom in determining how their relatives are cared for. We need some form of commitment from the family to cover some of the expenses when they require care beyond that

Dr. Stead is the Florence McAlister Professor Emeritus of Medicine, Duke University Medical Center, P.O. Box 3910, Durham, NC 27710.

needed by the average person with cognitive brain death. The payment could be either in money to spare the public purse or in services which require some sacrifice on the part of those requesting services more to satisfy the well person than the cognitive brain dead patient. It is impossible to limit costs unless the persons requesting the services have some skin taken off their behinds.

‘It is impossible to limit costs unless the persons requesting the services have some skin taken off their behinds.’

I have always wished to leave the decisions about the manner of dying to the family. Professionals can project their prejudices over many families. Families are self contained. If injustices are done they are limited. There is no absolute justice in the world. If you are unlucky to be part of a nasty family — that's life. All souls cannot be saved. There will be abuses in any system. We should use methods which tend to limit the abuses to the smallest number of persons. ■

A Window On Emory's History: Pre- and Post-Stead

Charles D. Hollis, Jr., M.D.

PRE-STEAD and Post-Stead: The history of the Emory University School of Medicine can logically be divided into the two eras.

Pre-Stead Emory was a traditional Southern medical school. Prominent community practitioners offered their time and talents to lecture, go on rounds, and scrub with students and house staff. There were few, if any, full-time faculty.

Eugene Stead, a native of Decatur, Georgia, left Emory and migrated to Boston into a different, emerging teaching environment. Following in the tradition of Sir William Osler at Johns Hopkins, the first prototype of the consumate internist-professor, Dr. Soma Weiss, at Harvard's Peter Bynt Brigham expanded the model of the complete professor. He would meld clinical skills and inspirational leadership with the qualities of the research scientist, bringing all to the bedside of the teaching hospital. Eugene Stead was an apt and receptive pupil and became the protege of the visionary Dr. Weiss.

Dr. Hollis practices internal medicine. He is a Past President of the MAG and Chairman of the Board and CEO of MAG Mutual Insurance Company. His address is 1610 North Valencia Dr., Albany, GA 31707.

"Dr. Stead was an awesome as well as inspirational leader. He had an incessantly inquiring mind. He stated things in a unique, colorful way, difficult to forget."

In the early 1940s, Dr. Stead was asked to come back to Emory to develop the new ideas in medical teaching in Atlanta. Such was his leadership that he was able to attract a dozen of the most brilliant of the young internal medicine staff at Harvard to join him in structuring a "Brigham in Atlanta." Dr. Stead believed that medical teaching, like medical practice, was a full-time job. He insisted upon full-time faculty in his department. That faculty did, indeed, build the department he envisioned, and, one by one, these young teacher-scientists moved on to lead major medical institutions around the country.

Dr. Stead was an awesome as well as inspirational leader. He had an incessantly inquiring mind. He stated things in a unique, colorful way, difficult to forget. "I think medicine is fun, don't you!," he was frequently heard to say. "It's odd, don't you think?" "That seems curious to me." "I wonder why." And his young students would rush to the library to try to discover why. "It's strange that you wouldn't know that," he would say, and the next time the trainee would know. "I don't believe I'd want you on my team," was said if some important matter was neglected. It was not likely to be neglected again.

Dr. Stead was tireless and expected enthusiasm for medicine to make everyone else tireless. It was part of his pattern to appear at the hospital at 2 am, catch a weary resident by the arm and say, "Let's make rounds." The house officer was expected to know every detail about every patient on a ward, whether or not the patient was his primary responsibility.

Eugene Stead was a legend in his own time at Emory, a legend that has been perpetuated by the frequent recalling of antidotes by those fortunate enough to have fallen under his influence. "Doesn't it seem curious?" "That seems odd, don't you think?" "I think medicine is fun, don't you?" And he made it fun — fun and a challenge — to all those about him. ■

Health Care Reform: How Deep, How Wide?

Daniel Callahan

THE QUESTION before the American health care system, I propose, is this. Can we have an equitable and affordable health care system within the boundaries of its present moral, social, and scientific values? Or, put alternatively, can our present system be seriously reformed without changing some of its deepest, most revered values? My answer is: no. Our present crisis is not only one of efficiency, affordability, and equity. It is at root a crisis about what we believe a health care system should try to do, what its ultimate goals should be.

The most popular view in this country, among both legislators and health policy analysts, is that there is nothing wrong with the goals and values of our system. Those values include a belief in unlimited medical progress, in endless combat against illness and death, in giving both patients and physicians a considerable freedom of choice, and in keeping the role of government to a minimum. The real problem, it is said, is that we have an inefficient, fat system. A better set of incentives and disincentives, together with better technology assessment, would enable us to pursue our most revered values with no serious compromise.

I consider that view a form of wishful thinking, a kind of medical pious hope. Consider some of the realistic objections to that hope that can be raised.

For all the talk of cost containment, we have not after 20 years of trying, found a way of making it work, especially in a way that would avoid rationing. We have tried competition, HMOs and managed care, DRGs, and other economic incentives. For all that, costs continue to rise at a ridiculous rate.

Is more research the answer? Despite powerful evidence that it is the success of medicine, not its failures, that are the source of our greatest costs, many still entertain the unrealistic notion that research and progress will sooner or later save us money. While here and there that might be true, the historical record speaks against the likelihood that medical advances will sooner or later save money. The mistake is to assume, since we inexpensively and effectively got rid of the major plagues and infectious diseases, we can do the same with the chronic, degenerative diseases of old age. No good evidence exists that anything like that will happen.

What about the role of government? As much as it would be nice to keep that role to a minimum, the experience of every other developed country indicates that a strong government hand is necessary to effectively manage costs. The only country that allows the market to have a strong play — ours — is also the most expensive, most inefficient, and most inequitable. That does not seem accidental. The issue is that choice, and the use of markets, cost money. Wealthy people have more choice than poor people because they have more money. We somehow want both to maximize choice and maximize efficiency. That is a most implausible mixture.

‘Can our present health care system be seriously reformed without changing some of its deepest, most revered values? My answer is: no.’

One way or another, I conclude, we will have to re-examine our deepest values. They are fine and good values.

Daniel Callahan, Ph.D., is Director of The Hastings Center and the author of *Setting Limits, Medical Goals in an Aging Society* (reviewed in the Book Review Section of this issue) most recently and of *What Kind of Life: The Limits of Medical Progress*. His address is 255 Elm Road, Briarcliff Manor, NY 10510.

They are also expensive values. We might well, moreover, profit medically from such a fresh examination. Not all so called progress has really bettered the human condition. Maximizing choice does not necessarily maximize wisdom. Hatred of government may not mean the end of government, only the growth of bad government.

American medicine has come through a glorious and expansionary era, one that began after World War II. That era is coming to an end. We now need to devise new goals, new priorities. We should stop kidding ourselves that we can have it all. We cannot. But we can still have a wonderful health care system. ■

Health Insurance Costs: The Snake That Needs Killing

Eugene Patterson

CONGRESS SIRED Medicare 25 years ago over the snarls of a potent opposition: elements of the medical, business, and insurance lobbies in league with conservative Republicans. Now, pressure is building on Congress to extend a national plan of health care not only to the elderly and the poor but also to everyone. And the troubled opposition alliance of the 1960s shows signs itself of cracking in the 1990s.

Business, big and small, is heading for the exit. Its preference for unregulated private enterprise as a principle remains in place; its survival instinct to control runaway costs is overridingly active now that health insurance costs have gotten silly. The Pepper Commission's proposal to require businesses to finance this ever-rising insurance finally tore it with chief executives who are struggling, as I did for the last decade, to create a rational expense budget for a company when the employee health item is out of control. Chrysler's Lee Iacocca says, "More and more business people are not just whispering but talking out loud about making health care financing a government responsibility." Iacocca is having to place a $700 surcharge on each car to cover his employees' health insurance while he's trying to compete with Japanese automakers whose government-subsidized health care costs are two-thirds less.

General Electric vice president Arthur Puccini says rising health care costs "may lead some of us who today are free market advocates to reexamine our thinking and positions with respect to government-sponsored national health insurance."

Health insurance costs already amount to some 15 percent of payroll costs among big companies in Florida. These companies were warned at a 1989 conference that recent annual increases of up to 25 percent will, at this rate, have them spending more for health insurance than for salaries by 2002. To the minds of the hardheaded people who manage U.S. businesses, this snake needs killing.

As for Republican politicians intent on holding the White House, they're feeling the heat from an overwhelming majority of the electorate which favors a fundamental change in health care (a Louis Harris poll last year found 9 of 10 Americans want such a change). These politicians are experiencing acute electoral discomfort at the figures they see: 37 million Americans without health insurance; health care costs rising twice as fast as inflation; 20 percent of U.S. health care spending, the world's highest, wasted on "paperpushers" in the woeful overlap of public-private bureaucracies.

"Based on public reaction observed from an editor's chair, fundamental change in the U.S. health care system seems certain to be the next explosively decisive issue in U.S. domestic politics."

Most important, the politicians are hearing not just from a group of interested and needful voters as they did in 1965 but from an unlimited spectrum of very angry ones, on a scale they cannot ignore. One example:

Mr. Patterson is Editor Emeritus of the *St. Petersburg Times*. He followed Ralph McGill as Editor of *The Atlanta Constitution*, serving from 1960-1968. His address is 1967 Brightwaters Blvd., Clearwater, FL 33704.

The *St. Petersburg Times* printed a pro and con exploration of Canada's national health plan last January 17, together with a coupon inviting readers to say whether they favored Canada's plan or the current U.S. system. A coupon is not a scientific sampling, of course. Still, the response nearly knocked the mailbox off the wall. More than 5,800 coupons came back, breaking every response record at the newspaper. When counting stopped, 5,677 favored the Canadian plan of universal, government-administered health insurance against only 140 who opposed it. The point was not lost on the Republican Congressmen who represent this Florida district where conservative midwestern natives predominate. The people who elected them want change, now.

So the conservative businessmen and the conservative politicians have started edging out of the old alliance, leaving the fort of the status quo to be held by an unlikely remnant of insurance interests clinging to the gown-tails of medical-hospital people whom they've been zapping for years with malpractice premiums which they have laid, of course, altogether to the lawyers.

The insurance industry possesses the megaphones to make its excuses heard without a lot of "on-the-other-hands" from me. Some unhappy facts are self-evident. A conflict of interest is built in: The more health care costs rise, the more the commercial insurers can collect in overhead for such wastes as maddening record-keeping, eligibility, deductible quibbling, and sales commissions. They assure their profits by dragging their feet on forming pools to share and shoulder risks. They rule out applicants with pre-existing conditions in observance of the jungle rule that if you need coverage, you cannot have it. And with more crocodile tears than seriousness about cost containment, they charge so much more money for so much less coverage each year that U.S. companies, led by the small ones, are dropping coverage entirely on a million workers a year. It used to be said that even the foremost advocates of a national health program doubted Congress could ever by persuaded to take the health insurance profits away from the insurance industry. That may no longer be necessarily so.

"The conservative businessmen and the conservative politicians have started edging out of the old alliance, leaving the fort of the status quo to be held by the unlikely remnant of insurance interests clinging to the gown-tails of medical-hospital people. . . ."

The question arises, then, as to what so many nice people in the American Medical Association are doing on this last rampart with the insurance crowd.

Doubts about Canada's system have some logical footing among American doctors and hospital people. On the plus side, Canadians loosened the British system of government-controlled doctors and hospitals. Canadians choose and go to their own doctors who practice independently. But virtually all medical bills are paid with tax money except for eyeglasses, prescriptions, and cosmetic surgery. Federal guidelines, administered by the states (provinces), set fees charged by doctors and hospitals. But patients are not forced to go to doctors they did not choose or enter hospitals they do not trust. So Canadians have greater freedom of choice than American members of health maintenance organizations or preferred provider networks. Canadian oversight regulates construction or expansion of unneeded hospitals and puts a brake on cost-ineffective competition based on underutilized lithotriptors or magnetic resonance imaging machines bought to help hospitals steal patients from each other.

On the down side, the Canadian plan rations care, restricts equipment purchase, limits immediate access to MRI devices and such procedures as angiograms, coronary artery bypass surgery, and organ transplants. Nobody claims there aren't some unhappy trade-offs between the U.S. and Canadian systems.

"Commercial insurers assure their profits by dragging their feet on forming pools to share and shoulder risks. They rule out applicants with pre-existing conditions in observance of the jungle rule that if you need coverage, you cannot have it."

The point has been reached, though, when Americans have lost patience with the cost, confusion, and inadequacy of a U.S. system that rations health care according to who can pay — and thus leaves out millions. Based on public reaction observed from an editor's chair, fundamental change in the U.S. health care system seems certain to be the next explosively decisive issue in U.S. domestic politics. Cost? People who study these things believe transfer of the private monies now being spent on health care to a central, non-duplicative public fund might even cost less.

I believe doctors, with their clear daily view of the public disadvantage weighed against private advantage in the present system, are not going to be comfortable sharing a bed with the insurance industry much longer. Insurance people did not make a pledge as physicians did at their graduation saying, "I will, under all circumstances, use my knowledge in the service of humanity. The health and life of my patients will be my first consideration."

Doctors know the present system is an unjust mess. I think I heard the sound of a better future when the 68,000-member American College of Physicians resolved that, "The current situation is intolerable for patients, their families, and physicians," and concluded that nothing less than national, comprehensive health care can "reaffirm the sanctity of humankind, the primacy of the patient, and the importance of good health for all our citizens, not just those who can afford it."

I do believe affirmative inputs from doctors can create a humane and sensible new system this time around. ■

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The Ethical Dilemma: To Do or Not To Do

Edmund D. Pellegrino, M.D., David M. Zacks, J.D.

THE ANNUAL TEEM lecture program was established in 1977 by Kennestone Hospital in honor of Dr. Martin Van Buren Teem, Sr. Dr. Teem was Kennestone Hospital's first Chief of Medicine and an original member of the Kennestone Hospital Medical Staff. The 1990 meeting, held at Kennestone Hospital on March 19, focused on ethical issues which the staff had previously identified as most compelling.

Ethics is a discipline. It is a form of study, a systematic examination of the rightness and wrongness of human acts. It has a set of rules and a body of literature.

Dr. Robert Harper: I want to welcome all of you to our 1990 Teem meeting. As Chairman of Kennestone Hospital's Medical Education Committee, I am very pleased to introduce our two speakers for this evening's program. Dr. Edmund Pelligrino is Director of the Georgetown University Center for the Advanced Study of Ethics in Washington, D.C. Mr. David Zacks, founding and managing partner of the Atlanta law firm of Knox and Zacks, specializes in health care law, antitrust matters and physician risk management. Gentlemen, we are honored to have you with us tonight.

Mr. Zacks: Since this is part of a lecture series, you may be surprised to learn that Dr. Pelligrino and I have planned a program which will not include a lecture. Instead, we want to give you the opportunity to raise some of the ethical issues which you have found to be problematic. Without further delay, we will take the first question.

Question: A 94-year-old man had given specific instructions to his son and daughter that his life not be prolonged through the use of feeding tubes or other mechanical means. This patient had not signed a Living Will prior to becoming critically ill. Over the physician's objections, the hospital administrator requested and obtained a court order to insert a feeding tube. As a result, the man had a poor quality of death. What, if anything, could have been done differently?

Dr. Pellegrino: I will try to respond in terms of the moral issues, and then Mr. Zacks can provide input from a legal perspective. From the ethical point of view, most people would say that if this man were competent when he gave instructions to his physician and his family, then those instructions would

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This article is derived from the taped proceedings of the Teem Lecture on medical ethics at Kennestone Hospital, Marietta, GA, in March, 1990.

have the moral weight in the decision-making. One of the most striking changes in medical ethics in the past 25 years had been this change in the locus of decision-making from the physician to the patient and the patient's family.

So the general rule, with one or two exceptions, is that the instructions of a competent patient take precedence over those of all other decision-makers. Any clear and unequivocal declaration (it does not have to be a Living Will) that comes from a competent patient is binding. If the patient is not now, but was once competent, his anticipatory declaration would be binding. This could be in the form of an oral or written statement to the family, a Living Will, a Power of Attorney, or any objective guidance that the patient wanted a particular course of action followed. In this case, I think the ethical issue was clear cut.

The second point this case brings up is the potential conflict between law and ethics. The fact that a course of action is legal does not mean it is also ethical. I am assuming that this patient was in a terminal state and that forced feeding would only prolong the act of dying.

The field of ethics encourages people to sit down together, as we have done tonight, and look at the inconsistencies in our and each other's perceptions. This provides an opportunity to clarify our positions and to understand our own logic and the presuppositions from which it arises.

If this is so, it was improper for the hospital administrator to go to court in violation of the patient's express wish. The court's agreement with the administrator does not justify that course of action. Ethically, the patient's instructions should have been honored. I think that, in this instance, turning to the law created a problem.

I would defend the administrator's action if he felt in good conscience that he was cooperating in something he felt was gravely wrong. But I suspect the administrator turned to the court for protection against future legal action. From my own experience as a hospital administrator, I understand the problems administrators must confront. However, in this situation, where all decision-makers were in accord, intrusion was ethically unwarranted.

Mr. Zacks: In many instances, as in this situation, the legal and ethical positions are diametrically opposed. As we await the Supreme Court's decision on the Cruzan case,[1] the law forbids, even when a Living Will has been executed, the withholding of nutrition. However, during the 1990 Session, the Georgia General Assembly passed the Durable Power of Attorney For Health Care Act.[2] This piece of legislation goes beyond the Living Will in protecting the wishes of the patient.

The Durable Power of Attorney For Health Care Act gives each individual the flexibility to specify which measures should be utilized or avoided. It provides a range of alternatives from withholding all intervention, including nutrition, to using the full array of medical technology to prolong life. Because it is important to closely follow the statutory form, this will be a very inexpensive document for your patients to execute. The Durable Power of Attorney For Health Care Act would bring the law into line with ethics in situations characterized by this 94-year-old patient. And I concur with Dr. Pellegrino that ethically, because their instructions were based on their father's clearly stated wishes, this patient's son and daughter should have prevailed.

Dr. Pellegrino: Using a feeding tube is considered to be an ordinary measure, but ethically, an individual can for grave reasons refuse ordinary as well as extraordinary measures.

Mr. Zacks: It should also be noted that intervening with a competent adult patient who does not want treatment may constitute the tort of assault and battery. But when a health care attorney gets a call from a hospital requesting counsel on sustaining life or allowing a patient to die, and there is no time to study the issue, the response has always been to preserve life. I'm not saying that's right; I'm saying that's prudent from a legal perspective.

Dr. Pellegrino: The ethical perspective would also support preserving life when in doubt. But very often the facts are unequivocal, making the decision unclear.

Before moving on to the next question, I want to expand on the concept of the rights of patients. There are limits on the patient's autonomy. One limitation is when the patient asks us to do something that violates our own values. We are not merely instruments of the patient; we have a moral accountability to our own belief system whatever that may be. Just as we cannot impose our will on the patient, the patient cannot impose his/her will on us.

There may be times when we must respectfully tell a patient we cannot be his/her physician under the circumstances he/she proposes. The rule that the competent patient makes the decision is general, not absolute. We cannot use the principle of patient autonomy to justify our failure to be morally accountable. We have to look at this whole issue in a much more sophisticated way than we have in the past. The physician's decision to re-

main or withdraw from a given case is one important factor.

Question: Have there been any lawsuits stemming from a physician writing "no code" on a patient's chart?

Mr. Zacks: I'm not aware of any such suits. But physicians must always practice good risk management by maintaining a chart that is well documented in terms of the patient's illness and the fact that there is no realistic possibility of recovery.

Question: Are Living Wills always enforced or can they be revoked by a member of the patient's family?

Mr. Zacks: A Living Will cannot be revoked legally by anyone other than the person who executed it. Thus, a family member cannot legally revoke a patient's Living Will. Of course, there have been cases in Georgia where a family member decided they did not want their relative's Living Will enforced. This obviously complicates an already difficult situation. It is one reason the Durable Power of Attorney is a more powerful document.

A Living Will is only set in motion when death is imminent. By contrast, the Durable Power of Attorney can be implemented under other conditions. The following excerpt from the latter document illustrates the scope of its authority.

> *The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care including withdrawal of nourishment, and fluid, and other life-sustaining measures if your agent believes such actions will be consistent with your intent and desires.*

If a patient wishes to limit the scope of their agent's powers, those limits can be clearly established. The force of the Durable Power of Attorney document extends even beyond death; enabling individuals, through their agent, to make anatomical gifts. I would recommend that all physicians advise patients to give serious consideration to completing a Durable Power of Attorney rather than a Living Will. If the provisions of a Living Will and Durable Power of Attorney are in conflict with each other, the latter document prevails.

Ethics is not concerned with what everybody else is doing; ethics is concerned with doing what is right. Our profession is de facto a moral community, and this gives us a special obligation to set the standard. . . .

Question: Please discuss the issue of physicians referring patients to a facility in which they have a financial interest.

Dr. Pellegrino: The conflict of interest issue is probably one of the most sensitive at the present time. Under certain circumstances, some of these referral practices have been endorsed by the American Medical Association's Council on Ethical and Judical Affairs. But from an ethical perspective, I would consider financial incentives of this kind very perilous and not morally sustainable. It is simply not possible for most people to separate their financial self-interests from the interests of the patient. The conflicts may be subtle, but they must be avoided.

We cannot risk that kind of conflict when we are committed to acting in the best interests of the patient. The contrast between our profession and a business is our ability and willingness to act in the best interests of the patient even when that runs counter to our own interests. If we don't preserve that principle, the essence of what makes us a profession will be lost. Any time we fail to act with the patient's interests as primary, we violate what is at the very heart of being a physician.

I frequently hear from hospital administrators as well as physicians that they must take a course of action, purchasing equipment or making a referral, because "everybody else is doing it." If we accept that argument, nothing will ever change, and we might as well forget any consideration of ethics. Ethics is not concerned with what everybody else is doing; ethics is concerned with doing what is right. Our profession is de facto a moral community, and this gives us a special obligation to set the standard, to point the way.

Physicians should advise patients to give serious consideration to completing a Durable Power of Attorney rather than a Living Will.

Mr. Zacks: I will review the legal aspects of patient referral to a facility in which the physician has a proprietary interest. The Stark bill, also referred to as the Ethics in Patient Referral Act, would have barred a physician from referring a Medicare patient to any facility with which the physician or any member of his/her family had any compensation arrangement or investment. However, the amended bill, due to take effect in January, 1992, only

bars such referrals to clinical laboratories.

The Safe Harbor Rules, due to be published in late Fall of this year,[3] will specify which payment practices are not prohibited under the Anti-kickback Statute with respect to referral of Medicare and Medicaid patients. Hopefully, these Rules, along with the amended Stark bill, will establish some reasonable, consistent guidelines.

Question: Dr. Pellegrino, referring to your comments on conflict of interest, isn't fee-for-service a conflict of interest?

Dr. Pellegrino: In a sense, yes. But ethics does not require us to be superhuman. We cannot eradicate everything. While there is a degree of conflict in the fee-for-service system, it is far less than the conflict inherent in referrals to a business in which we have a financial stake. One way to mitigate the conflict engendered by the fee-for-service system would be to establish a national fee schedule. We could also develop a better monitoring system to determine whether procedures are effective or indicated.

Mr. Zacks: To give you some understanding of the complexity of these issues, you just heard Dr. Pellegrino suggest the use of fee schedules. I am not saying that I personally disagree with fee schedules, but they happen to be illegal. Let me refer you to the Maricopa case in Arizona. The members of an Arizona community medical society decided that their fees were too high, so they got together and reduced them proportionally. As a result, the Department of Justice charged the physicians with violating the antitrust laws against conspiring to fix prices. The intent of the membership was irrelevant to the Justice Department. They viewed the action of the medical society as anti-competitive and therefore illegal.

Dr. Pellegrino: And that is only one example of what has occurred. The Federal Trade Commission, in their interpretation of the Sherman Antitrust Act, has classified our profession as a business in the same way they have classified engineering and law as businesses. They have also said that preservation of competition is the final and ultimate principle. As Mr. Zacks just graphically recounted, that principal holds even when we collaborate for the benefit of patients!

That brings me back to the fact that, regardless of how the Federal Trade Commission classifies us, we are a different kind of community. I must emphasize that point because I am frequently asked by physicians why we should adhere to higher ethical standards than others. Though all physicians must answer that question for themselves, I can tell you that if we do not preserve that difference, we will lose the essence of who and what we are.

Question: To me, the ethical issue is not where we refer or what we own; it is the manner in which we respond to each patient. In dealing with a patient's problem, are we looking for financial gain or are we trying to provide the best possible treatment? From my perspective, the question is not whether I have a financial interest in an MRI scanner, it is my rationale or motive for referring a particular patient for an MRI scan.

Dr. Pellegrino: I agree that how we handle each patient is the ultimate test. But we are human beings, and it is very easy to delude ourselves that we are acting in the interests of our patients when, in fact, we are not. We expect surgeons to make a determination about operating based on the indications for surgery. But a surgeon's lifestyle can subtly influence his/her decision and his/her rationale with routine procedures that have few risks of complications. What we must do, given this imperfect world, is to reduce conflict-of-interest to a minimum.

Question: A 16-year-old patient whose mother is a Jehovah's Witness, and who is being raised as a Jehovah's Witness, needs a transfusion. Though the patient's father is not a Jehovah's Witness, he supports his wife's decision that their minor son not be given the urgently needed transfusion. How do we respond?

Mr. Zacks: Under Georgia law, you are required to have a guardian appointed by the court, regardless of the parents' religious convictions, in order to protect the life of the minor. A court order for guardianship can be obtained orally, even at 3:00 in the morning, if needed. Once the transfusion had been given, guardianship would be terminated.

This is very different than the legal conclusion we would draw if we were dealing with a 35-year-old Jehovah's Witness who said he/she did not want a transfusion. In that instance, the patient can be allowed to die.

Dr. Pellegrino: Ethically, our approach would be very different from the approach of the courts. First of all, I would want to know the feelings of the minor. We do not use age alone to establish competence. The question is, irrespective of age — is this young man competent? Does he understand the question? Does he understand the risk, including the real possibility of death? Does he understand the relevance of the decision you are asking him to make? Can he make this decision based on his personal values? Is his decision consistent with those values? Is it free of coercion by parents, physicians, etc.?

Question: Though I presume he could meet the criteria you have just outlined, I question whether a minor should have the authority to

make that decision. I think individuals continue to be designated as minors at the age of 16 because they are simply not wise enough to make that kind of judgment.

Dr. Pellegrino: A 16 year old can have religious beliefs. Would you want to deny any individual, regardless of age, their beliefs? Jehovah's Witnesses believe they become contaminated if they receive blood. So if you override a young Jehovah's Winess his/her religious beliefs by ordering a transfusion, you have taken away something he/she considers more valuable than life. If this young man is competent by the definition I have given and shows consistency in his religious beliefs, I would honor his refusal to consent to a blood transfusion.

The conflict of interest issue is probably one of the most sensitive at present. . . . From an ethical perspective, I would consider financial incentives of this kind very perilous and not morally sustainable.

In any case, how do individuals suddenly become competent on their 17th birthday? Do they really become competent at 16 ½ or not until they reach 17½? What is the measure of competence? Does someone really become competent because the law says, based on age, that they are competent?

Mr. Zacks: The law tries to provide guidelines. Perhaps we are off by a couple of years one way or the other, but we still need parameters. The age of majority used to be 21, now it is 18. The law may not always be right, but it is the best we have.

Dr. Pellegrino: I would like to tell you about one of my own patients, a 15-year-old Jehovah's Witness whose legs were caught in a hay baler. His hematocrit was 12. He told me that he did not want a blood transfusion. He understood that there was a very real possibility that he would die without this procedure. But he felt, based on the teachings of his religion, that he would be contaminated if he received a transfusion. A very important point is that this 15-year-old did not feel being faithful to his beliefs would save his life.

There are some things, including religious beliefs, that transcend both the law and bodily integrity. I do not happen to agree with this patient's beliefs; I see them as a misinterpretation of the book of Leviticus. But the point is, the young man was sincere in what he believed. It took me a lot of self-searching to make a decision about his competence, but ultimately I was convinced that I would be assaulting him more by ordering a transfusion than by allowing him to follow his religious principles.

The fact that my patient recovered brings me to a second point. Too often we resort to transfusions when they are not necessary. We need to reevaluate our criteria for recommending this procedure.

Question: What if refraining from giving a transfusion, when this may result in a patient's death, goes against your beliefs as a person and as a physician?

Dr. Pellegrino: Then you must respectfully explain to the patient why you cannot continue as his/her physician. I want to emphasize that I am not talking about abandoning the patient. Abandonment is walking away from a patient without making arrangements for continuity of care. Obviously, you must remain on the case until another doctor is available. There are physicians who would feel comfortable handling the case in a way that would be consistent with the patient's beliefs. We must protect the religious beliefs of both physicians and patients, especially in a pluralistic society such as ours.

Question: Can you differentiate between ethics and religion?

Dr. Pellegrino: Ethics is a discipline. It is a form of study, a systematic examination of the rightness and wrongness of human acts. It has a set of rules and a body of literature. One may approach ethics from the perspective of human reasoning, from the perspective of human reasoning plus revelation, or from a more fundamentalist approach, one which asserts that ethics is derived from the Bible or other scripture. A methodist, a Jehovah's Witness, and an atheist would be likely to start their ethical reasoning from a different set of ethical assumptions. Religion introduces a moral imperative from a source beyond the human realm. It calls for a faith commitment, while ethics is limited to what reason alone can tell us.

These differing perspectives might lead people to question the value of ethics. Remembering that ethics is a systematic examination of the rightness and wrongness of human acts, it provides a framework out of which we can make moral decisions in a conscious, rational manner. Ethics provides a forum for people who are trying to understand both their own position and the position of others.

The field of ethics encourages people to sit down together, as we have done tonight, and look at the inconsistencies in our own and each other's perceptions. This provides an opportunity to clarify our positions and to understand our own logic and the presuppositions from which it arises. Given some of

the tough issues we are going to be facing — abortion, voluntary euthanasia, involuntary euthanasia — it is critical that we be able to argue for or against an issue from a rational perspective.

Mr. Zacks: Dr. Pellegrino and I both feel very strongly that every hospital must have an active ethics committee. Physicians and nurses must have ongoing opportunities to clarify their positions and to share information. When people have a clearer understanding of the other staff members' positions, the air is cleared and better decisions on patient care result.

I know we are out of time. Dr. Pellegrino and I both want to thank you for allowing us to talk with you about these issues that are so critical to all of us.

The rule that the competent patient makes the decision is general, not absolute. We cannot use the principle of patient autonomy to justify our failure to be morally accountable.

Dr. Harper: Mr. Zacks and Dr. Pellegrino, on behalf of everyone here, I want to thank you for taking time out of very busy schedules to be with us. The questions asked and your responses focused on some very pivotal issues for us as a medical staff. The information you have each provided will enable us to increase our responsiveness to our patients and their families as we struggle with these very difficult issues.

References

1. On June 26 of this year, the U.S. Supreme Court upheld the State of Missouri's refusal to remove a feeding tube from Nancy Cruzan. This ruling was based on the lack of clear and convincing evidence that the patient would want the feeding tube to be removed.
2. On April 11, 1990, Georgia Governor Joe Frank Harris signed The Durable Power of Attorney For Health Care Act, #1259, into law.
3. The Safe Harbor rules have not been published yet.

Ethics in Health Care: What Do We Have To Do? What Should We Do?

James T. Laney, Ph.D.

We need to fund preventive medicine instead of defensive medicine. We need to learn again our finitude, so that more of our limited resources can be devoted to embracing life rather than denying death.

As the 1990s sneak in this month, and we begin to ponder what we might expect them to hold in store for us, it might be instructive to look back at the beginnings of the 1980s, to two phenomena that have had an enormous impact on the community's expectations about health care. One of these phenomena is AIDS, of which the first cases in this country were reported in New York and Los Angeles in 1981. The second phenomenon is C. Everett Koop, who was appointed that same year as Surgeon General of the United States (arguably Ronald Reagan's best act as Chief Executive). These two phenomena have essentially shaped dialogue about public health during the past decade.

On the one hand, AIDS has severely tested current medical know-how and spread a pall over the personal lives of millions. It has also raised knotty questions about the role of government in delivery of information, services, and resources. On the other hand, Dr. Koop has done probably more than any other single individual to raise public awareness about the dangers of smoking, alcohol consumption, and obesity. He has both reflected and helped establish a new national health agenda, which places at least as much emphasis on preventing illness as curing it. Together, the private ravages of AIDS and the public service of Everett Koop suggest the forces at work in setting the community's expectations about health care in the next decade. They suggest, too, that the difference between what we *have* to do and what we *should* do is small indeed; that what we *have to do* — as a matter of economic prudence, political judgment, and corporate common sense — is also what we are called to do as a matter of social justice and common good.

I am not advocating here a utilitarian calculation of the social good. My sense is that when it comes to talking about health care we have already gone too far in talking about its cost to society. We all can recite the staggering statistics: In June, 1988, the Machinery and Allied Products Institute released a survey showing that between 1950 and 1986 the percentage of the Gross National Product devoted to health care rose from 4.4 percent to 10.9 percent, and will approach if not surpass 13 percent by 1992. Insurance costs are rising at the rate of 16 to 20 percent a year.

At the same time, the medical

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Two phenomena in the 1980s have had an enormous impact on the community's expectations about health care: the outbreak of AIDS and the appointment of C. Everett Koop as Surgeon General. These two phenomena have essentially shaped dialogue about public health during the past decade.

At the same time, the medical welfare net spread under the poor and elderly by the Great Society programs of 20 years ago are showing gaping holes: Medicaid covered 65 percent of the population below the poverty line in the mid-1970s but only 52 percent in 1987. And in some states, with very tight limitations in force, Medicaid helps only 20 percent of those who live in poverty. As for Medicare, one study has projected a $300 billion deficit in the trust fund by 1995 and a $1 trillion deficit by 2005 — when the first of the Baby Boomers will just be approaching retirement. Add to that the fact that the average age of the American population goes up each year, and it is not difficult to see crisis looming for the next generation of senior citizens. In 1900, 4 percent of the poulation were over 65; in 1983 that number had increased to 11 percent; in the year 2000 it will be around 17 percent. The fastest-growing age group in the country is that of people over 85 years old.

At the other end of the age spectrum the picture is no more encouraging. The infant mortality rate in the U.S. has remained somewhat steady over the past decade but still ranks near the bottom for industrialized nations. Since infant mortality is directly attributable to such factors as nutrition, shelter, prenatal care, and postnatal care, it indicates fairly well a society's general level of health. In the U.S. it serves as an indictment. Compared to Sweden, which has the lowest infant mortality rate in the world, the U.S. has much work to do. In Sweden, 99 percent of pregnant women enroll in prenatal programs before the end of their first trimester of pregnancy. In the U.S., the figures are 80 percent for white women and 62 percent for black women.

One final set of statistics suggested by this last: the statistics on health and poverty. Last year, following 8 years of the most far-reaching transfers of tax burdens and benefits since the 1960s, the bottom 40 percent of the population received less than 16 percent of the nation's income — the lowest figure since 1947, when such figures were first kept. Unfortunately, the decline in income for the bottom half of the population has meant a diminishment of their access to health care as well. In 1977, 25 million Americans — mostly the working lower and lower-middle class — lacked health insurance. One decade later that figure was 35 million.

The Robert Wood Johnson Foundation estimated that of 1 million Americans refused admittance to hospital for financial reasons in 1986, 80 percent were "black, Hispanic, poor, or uninsured." Yet these are precisely the people who need good health education and good health care. Chronic illnesses, such as heart disease, are twice as prevalent in lower income groups as in the rest of the population. And while low-income males are more likely than their wealthier counterparts to require coronary bypass surgery, they are half as likely to have it done.

All of these numbers, of course, serve two helpful functions. They help point out America's growing burden of paying for health care; and they help direct our planning for the next decade and beyond. Also, they emphasize how easily our society has learned to weigh costs and benefits when discussing what is really a matter of life and death — for individuals and, perhaps ultimately, for "the American dream" as well. As the dollar figures and percentages swirl in the debate about how to contain the spiralling costs, how to expand the limited pie, how to repair the fraying net beneath the needy, it becomes more and more clear that the *image* of health care is changing. The conversation focuses less on the care for the individual, and more on the care for society; less on medicine as a service or mission, and more on the "health industry" as a "business" with a "product" called healthy people.

If the decade-long struggle with AIDS has had any good effect, perhaps it has been to teach us again that where health care is concerned, education is at least half the battle.

We are rapidly building a two-tier healthcare system driven by management objectives borrowed from the business world. And while there may be nothing intrinsically wrong with such objectives in the realm of corporate finance and manufacturing, they do not necessarily translate well to the realm of patient services. Cost-containment devices such as the diagnostic related group (DRG) do not really contain costs, as we all know;

rather, they move patients out the door "sooner and quicker," as the phrase goes.

Clearly, as the statistics and the trends and the projections all underscore, something must be done. It has been nearly 30 years since the President's Commission on Health Care Needs of the Nation called access to health care a basic human right. What do we *have* to do to make that right a reality for everyone in our community as we move toward the next millennium? What *should* we do?

I want to return to the two phenomena I mentioned earlier — AIDS and the Surgeon General — as a way of suggesting that what we *have to* do is also what we *should* do: that what is required as a means of comprehending and controlling the forces that now seem to control *us*, is also what is required as a matter of civic responsibility and human decency.

If the decade-long struggle with AIDS has had any good effect, perhaps it has been to teach us again that where health care is concerned, education is at least half the battle. Much of the fear about AIDS was and continues to be generated by ignorance; and much of the spread of AIDS was and continues to be fostered by our slow response and our hand-wringing over whether to say all we know about the precautions necessary for "safe sex."

Similarly, the former Surgeon General has taught us that we need to be teaching healthy living. As early as 1976, while still Surgeon-in-Chief of Children's Hospital in Philadelphia, Dr. Koop estimated that "as much as half of U.S. mortality" could be attributed to what he called "unhealthy behavior or lifestyle." It has been estimated that if the best possible medical care were available to everyone, the life expectancy of the average American would increase by three years; while if every American would eat sensibly, exercise regularly, and not smoke, the life expectancy would increase by 11 years.

The greatest fear among the elderly is fear of the nursing home. Better to *die* of a stroke at a vigorous 70 than merely to *suffer* a stroke and watch your assets be drained by a dozen years of life-support machinery.

The question this poses is whether those additional 11 years would be worth the effort. As one member of the AARP has put it, "The universal dread of death has finally caught up with the equally terrifying fear of being 'kept alive.' " The greatest fear among the elderly is fear of the nursing home. Why? Partly because of outmoded but lingering images of the poorhouse and institutionalized cruelty to the aged and infirm. And partly because nursing homes so often mean prolonged illness and financial ruin. Better to *die* of a stroke at a vigorous 70 than merely to *suffer* a stroke and watch your assets be drained by a dozen years of life-support machinery.

What we are learning is that, ingenious and even miraculous as all our medical technology and know-how are, they do not always enhance life, and they cannot unmake the irrevocable choices we often make. We need to encourage wellness as well as cure illness. We need to fund preventive medicine instead of defensive medicine. We need to learn again our finitude, so that more of our limited resources can be devoted to embracing life rather than denying death.

As a society we need to choose our course, and soon. Will we continue along the path we have been following, in which exotic and staggeringly expensive medical science holds out the hope of longer life for some, only if we ignore the basic health of 35 million of us? Will the government continue its retrospective financing of "defensive medicine," when it might better promote "the general welfare" through prospective financing of preventive medicine? Will we continue to lurch into whatever brave new world may await us in the next century — a world shaped by our ad hoc response to crisis through the court systems — or will we begin to articulate a realistic vision of what health might mean for mortal Americans at the end of this century?

I have no optimistc expectations about the ease with which any of these choices can be made. I am certain, however, that as a society we are well aware, by this late date, of the reality that confronts us. In the words of the National Center for Health Services Research: "We are moving from pursuing health goals 'at any price' to a realization that limited resources require deliberate choices. The goal of 'the best for everyone' provides no guidance for making trade-offs among alternative uses of resources when that goal cannot immediately be achieved." The question is whether as a society we share expectations about health care to a sufficient degree to guide us in our choices over the next decade. I believe we do. In closing I want to enumerate some of those shared expectations and outline their implication for our ethical deliberation:

First, as the social critic Michael Walzer has pointed out in *Spheres of Justice*, we share a belief that if illness *can* be cured, it *must* be. It *should* be cured; we have a *moral obligation* to cure it. Since the formulation of the Hippocratic Oath, the physician has been seen in

many different guises, from court physician to NIH researcher, but always, too, as one who will not let money (or its lack) stand in the way of an act of compassion. The good physician should also be the Good Samaritan. This expectation carries over to hospitals as well. And, thus, the national outrage when we learn from the media that hospitals have shuttled indigent patients to the nearest charity ward, or, worse, when the patient dies during the ambulance ride from one emergency room to another.

Will we continue to lurch into whatever brave new world may await us in the next century . . . or will we begin to articulate a realistic vision of what health might mean for mortal Americans at the end of this century?

Along with this first belief we share a second and related one — that medical care should be available to those who really need it. Physicians themselves deplore the amount of time they spend consulting with perfectly healthy but perhaps somewhat hypochondriacal patients, when the perfectly sick are languishing in the waiting room. Younger physicians now appear to be less ready to admit patients to the hospital, even when the rising numbers of malpractice suits would warrant their doing so out of self-defense.

We agree, I think, with the man who walked into the doctor's office complaining of headaches. The doctor ran a complete series of blood tests, ordered CAT scans, called in specialists, and prescribed a mild pain reliever. After a few days the man began to feel better. When the doctor presented a rather hefty bill, the man revealed that he was destitute and uninsured, and could not pay. The doctor, outraged, cried, "How could you in good conscience run up a bill like this, when you knew all along you couldn't pay?" And the man replied, "Doctor, where my health is concerned, money is no object."

Of course this apocryphal little story is a joke. We know that, because nowadays the patient would have been forced to swear out a financial affidavit and take out a second mortgage *before* treatment.

A third belief we share — one that will continue to direct our expectations about health care — is that government, especially the federal government, must and should devote vast public funds to the "medical-industrial complex." What is not so clear, however, is how this government commitment will be maintained. Currently the federal government spends hundreds of millions on medical research through the NIH alone, in addition to spending further hundreds of billions on direct health care through Medicare and Medicaid. Already the degree and manner of these commitments have become the focus of intense debate, as we have seen in the past year in congressional wrangling over Medicare, and that debate is likely to heat up as the tensions between the generations intensify.

Given these widely shared beliefs; given the aging of the population and the limits to exotic medical care; and given the lessons taught us by AIDS and the Surgeon General — I would like to suggest three ways we can approach the 1990s with the intention of making what we *have to do* reflect what we should to — making our prudent and cost-effective course of action a just and responsible course of action as well.

First, we have to begin to approach health care with a far more sensible acceptance of the limits to exotic health care, which essentially are limits to resources in general. As Daniel Callahan, a founder of the Hastings Center, has said, "In many cities in this country we have wonderfully equipped neo-natal intensive care units right down the street from terribly equipped schools. Does it make sense to devote such a tremendous quantity of resources to saving smaller and smaller babies, and then thrust them into a society that is characterized by second- and third-rate schools? We have skewed things too much toward health care as opposed to housing, education, and other things. Medical care cannot be allowed to trump everything else." (*NY Times Book Review*, December 24, 1989).

No one should underestimate the degree of political debate and compromise that will be entailed by our having to re-order our priorities. The public, the medical-industrial complex, and politicians might all have to give more than they want to on this matter. But one thing is clear: the American people over and over have voted for a basic level of health care for all; and in a world of scarce resources, this will mean limits to exotic life-saving devices. Increasingly public sentiment will favor the creation of "Living Wills," and of decisions made by a wider mix of people, including patients and their families. Hospitals and physicians will be challenged more and more to honor the wishes of those who have weighed length of life against quality of life and found it wanting.

Second, I believe that we will begin to see more discussion about quality of death as well as quality of life. The AIDS crisis has underscored what we ought to have learned from Elizabeth Kubler-Ross's studies of terminally ill cancer patients — that what we need to provide so often is a humane way of dying. I am not talking about eu-

thanasia, of course. I am talking about the need for hospices, nursing homes, and other chronic-care facilities for an older, more debilitated population. It is estimated that the ratio of nursing home beds to hospital beds will increase from 3 to 2 in 1989 to 5 to 1 in the near future. As death from acute illness decreases in our society, the paradigm of health care may shift from one of miracle cures to one of ministry to the weak and infirm.

Thus, the third way we can bring our "must's" into line with our "should's" will be to bring medical training into line with medical practice. Currently physicians in training spend about 80 percent of their learning time in acute-care settings, while the overwhelming needs of the community lie in the areas of long-term care and prevention of illness. At the same time, there has developed an acute shortage of physicians, nurses, and allied health professionals in rural regions and in areas like Indian reservations and inner cities — areas, that is, where the most urgent issues of health-care have to do with prenatal care, instruction in wellness, and help for chronic abuse of alcohol and drugs. Furthermore, it is increasingly evident that our medical school curricula no longer can stress rote memorization at the expense of training in problem-solving and, just as important, empathy. The forces at work in our society and the needs of our diverse communities are conspiring to help us re-image not only the paradigm of health-care delivery but also the training and the skills of the health-care practitioners. The skills of the human spirit in sympathy with another are becoming as important as the skills of medical technology, and the art of healing is regaining its place of honor alongside the science of curing. We must foster the continuation of such trends for the sake of a more secure system of health-care delivery and for the sake of a more humane society.

Finally, as a way of concluding these reflections on "what we have to do" and "what we should do," perhaps it is appropriate to think about what the vision and efforts of one man, working with many others, *did* do, for Georgia and for our region. The story has been told many times and in many ways — with enough variation in detail to give it the aura of legend — of how in 1929 Robert Woodruff was speaking to a man on or near his plantation at Ichauway, in Baker County. The man suddenly stopped talking, began shaking with a chill, and collapsed in front of Mr. Woodruff. That was Robert Woodruff's introduction to malaria.

At the time, the causes of malaria were well understood by medical science, and the use of quinine to cure it was well-established. Yet throughout southern Georgia and northern Florida, the disease sometimes reached epidemic proportions, affecting as much as 50 percent or more of the population in some counties. The effects of such widespread illness were enormous, both in terms of the immediate suffering that afflicted people and in terms of the economic consequences of farmhands' being incapacitated from working the fields.

Mr. Woodruff's first response was to order a barrel of quinine tablets and distribute the medicine free to anyone in Baker County who would take it under doctor's care. Out of this initial response grew a massive and enormously successful public health project that was one of the first drug prophylaxis programs in the country and served as a prototype for programs later implemented by the miliatry on a larger scale. It also led directly to the employment of a public health officer in Baker County. In 1939, Mr. Woodruff funded establishment of the Emory University Field Station to continue work in malaria research and control, and to begin a program to control hookworm disease, which then affected more than 60 percent of the children in Baker County.

At Emory University itself, one of Mr. Woodruff's first gifts was $50,000 to set up the Robert Winship Memorial Clinic in 1937 in honor of his maternal grandfather, who, like Mr. Woodruff's mother, had died of cancer. Cancer in those days was considered "a social disease," according to Mr. Woodruff's later reflections about the founding of the cancer clinic. People who could afford to would travel as far as the Mayo Clinic for treatment rather than let their friends know what their ailment was. Now, I do not know the source of this embarrassment about cancer. But Mr. Woodruff clearly saw the need to change it, and to make the finest treatment of cancer available in Atlanta. And, thus, from this beginning developed, over several decades, all the resources of the Robert W. Woodruff Health Sciences Center, which is part of a health-care network in this state that is the equal of any network in the country.

The point of these stories is not to boast, but to suggest what enlightened and visionary leadership can accomplish in providing health care. Thanks in no small part to Mr. Woodruff's designs, the state of Georgia enjoys some of the finest health care in the world. No one would suggest that this care is equally available to all, or that there are not enormous financial stakes behind the perpetuation of the system as it now exists, with all its inequities and inadequacies. The challenge of the 1990s, from the community's perspective, will be for all of us together to shoulder the responsibility of the next phase in this grand development. The next phase will be to re-imagine, as Mr. Woodruff did in Baker County, what it would mean to offer health to all, and to implement, as Mr. Woodruff did in Atlanta, a rational plan for re-educating people about health, even as we treat their illness.

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Medical Ethics: Prolonging Life or Protracting Death?

Betty C. Castellani

It is written in *Gulliver's Travels*[1] of the excitement experienced by our traveller when he learns of the Struldbruggs, the Immortals, who are spared death: *"Happiest beyond all comparison are those excellent Struldbruggs who, being born exempt from that universal calamity of human nature, have their minds free and disengaged, without the weight and depression of spirits caused by the continual apprehension of death."*

We, like Gulliver, long for immortality. Death must be avoided at all costs. Deciding who shall live and who shall die and who shall make the ethical, financial, legal, and medical decisions is one of the major challenges of modern medicine. The more technology advances, the more problems it creates. We have blood transfusions, intravenous feeding, antibiotics, respirators, organ transplants. We are able to maintain life beyond most expectations. But the price in economic measures and human suffering can be exorbitant.

The right to die when the quality of life is no longer acceptable to a competent individual should be a right protected by the law, respected by the medical community, and adhered to by family members and society. Fear is the major stumbling block, not lack of guidelines.

The right to die when the quality of life is no longer acceptable to a competent individual should be a right protected by the law, respected by the medical community, and adhered to by family members and society. Fear is the major stumbling block, not lack of guidelines. The medical community is afraid of the courts and the malpractice threat that is an ever present reality. The family member fears decisions that have the potential to produce feelings of guilt or even legal liability. Society fears the difficulties presented by standards of competency. Does "competent" tend to be what "we" might choose, and anyone who chooses otherwise must be "incompetent?" Patients fear death and some will go to extraordinary lengths attempting to evade it.

A glance at the contents of medical journals reflects an enormous increase in the number of articles written on the subject of Medical Ethics in recent years.

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That does not necessarily mean that we have become more ethical. In fact, we have become more alienated, and as we live in an increasingly alienated society, we can no longer depend on the quality of our relationships to assure a good decision-making process. We start looking for rules when we no longer trust our own instincts and inner sense of what is morally permissible and humane.

Hippocrates[2] said to one of his students, "Let your best means of treating people be your love for them, your interest in their affairs, your knowledge of their condition, and your recognized attentiveness to them." However, the climate of modern medicine with its fear of malpractice, its demands enforced by the technical explosion, and its economic stressors makes it very difficult to adhere to such a valid prescription to assure that good ethical decisions will be made.

Derek Bok,[3] president of Harvard University, places part of the blame on the medical educational process. He maintains that today's students are less well equipped than ever for moral and ethical decision-making. Education and religion no longer wield their traditional clout as instructors and enforcers of moral and societal standards. Students are taught to "cope successfully, without let-up, without feeling, with no signs of weakness and without asking for help."[3] Respect and caring for the individual patient have been largely replaced by extraordinary technology and specialization. The ability to intertwine these factors is neither taught nor encouraged.

Most patients facing the prospect of death want their wishes respected. They want to be able to share those intimate feelings with a doctor they trust. They want to be treated with a certain level of tenderness. They want a peaceful death when all possible has been done to restore health and function but before the maintenance of life has become an indignity. They want to remain conscious until their consciousness is only a deafening reminder of their pain. Most will endure great pain when there is some kind of hope for recovery but will surrender to it when it becomes all that is left of life.

That should be their right, and the relationship they have with their physician should enable that right to be exercised. There is no place in that ethical process for any court, society, religion, medical community or family member to take that right away. A person should be able to refuse invasive procedures that would maintain life. That includes medication, artificial feedings, respirators, treatments. We draw the line when a person wants to use invasive procedures to end life, such as a drug overdose or a lethal weapon. The first permits the passive acceptance of death. The latter involves the active pursuit of death. If a physician and a patient are engaged in a mutually caring relationship, there should be no conflict between reverence for life and the reality of death.

Medical technology has progressed too rapidly. We have . . . the means of prolonging life in a beneficial way for so many people. We also have the means of protracting death at enormous economic expense and emotional trauma.

Most of the literature in the area of medical ethics supports the thesis that each individual person should have the freedom to decide for themselves what quality of life is acceptable for them. If the ethical process we elect is the freedom of the individual to choose to accept or reject treatments, then a grave dilemma develops when a person is no longer competent to make those decisions. The right of decision making falls on the next of kin only to the extent that that person is assumed to know what the patient would want and will act on that patient's standards.

Georgia's recently enacted Durable Power of Attorney is a solid document for giving the patient the right to determine treatment decisions. It allows a person to designate someone to act in his or her behalf in the event that person is unable to make medical decisions. This person is not required to be a member of the family. Doctors and lawyers should encourage their patients and clients to become familiar with this document and to execute one for the patients' protection. In many ways, this document is just as crucial to the person's financial and familial well being as having a Last Will and Testament that directs the disposal of his or her material possessions.

In a startling case reported in Pennsylvania,[4] the wife of a diabetic patient was actually convicted of involuntary manslaughter because she refrained from obtaining aid when her husband entered into a diabetic coma that led to his death. He had chosen to stop taking insulin, confident that God would heal him.

On appeal, the court found that the husband, a competent adult and college chaplain, had the choice of accepting treatment or refusing it. Consequently, the wife's criminal conviction was reversed, and she was freed because she was found not to have had a legal duty to seek medical care under the circumstances.

The Durable Power of Attorney does not leave the patient's loved ones vulnerable. It clearly lets the family know what that patient wants done in the event of catastrophic illness or accident and the family member can have peace in carrying out those wishes.

We start looking for rules when we no longer trust our own instincts and inner sense of what is morally permissible and humane.

Medical technology has progressed too rapidly. We have at our disposal the means of prolonging life in a beneficial way for so many people. We also have the means of protracting death at enormous expense and emotional trauma. We as a society are not always sure of that perfect moment in time when we cease to prolong life and only protract death. However, most physicians are keenly aware when that moment arrives. Yet the fear of malpractice and the hunger for preserving life clouds the issue and the physician is not able to do as Hippocrates instructed so many years ago.

Physicians, courts of law, and each of us individually need to understand that our dreams of conquering death and disease by replacing organs and plugging in machines have a point at which they become destructive. At that point, medicine must step back and allow death to be the ultimate healer. We must understand that until our Creator decides to modify the design of the human being, death is an inevitable part of life.

Like us, at first glance, Gulliver sees all the joys of avoiding death, of becoming a living treasury of knowledge and wisdom and an oracle of nature. He realized, however, that *"this vision supposed a perpetuity of youth, health and vigor which no man could be so foolish as to hope for, however extravagant he might be in his wishes."*

In truth, the Struldbruggs, after their time of youth, grew melancholy and dejected, opinionated and incapable of friendship. They grew dead to all natural affections. They lost their teeth and hair, their memories and their tastes. They were still subject to the diseases and decay of all humanity. Whenever they would see a funeral, they would lament that others were allowed to go to a harbor of rest to which they themselves could never hope to arrive.

According to Gulliver, *"they were the most mortifying sight I ever beheld. . . . I grew heartily ashamed of the pleasing visions I had formed and thought no tyrant could invent a death to which I would not run with pleasure from such a life . . . the King, hearing of all of this, wished I would send a couple of Struldbruggs to my own country to arm our people against the fear of death."*

Perhaps we would do well to travel to Luggnagg and find some of those Struldbruggs and take them to the legislators who make the laws and the judges who seek to enforce them and the family members who confuse preserving life with living. Maybe then we could see the madness of maintaining life at all costs and the blessing of allowing death to come with the promise of peace it brings.

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MRI UPDATE

Figure 1

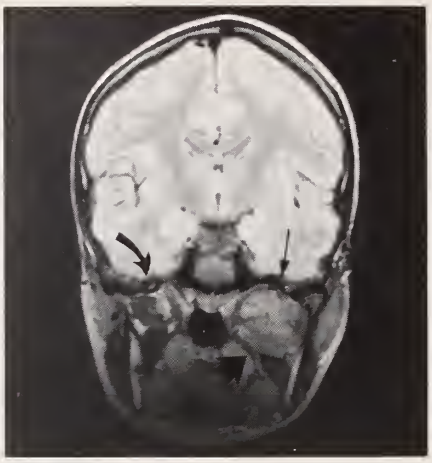

Figure 2

CLINICAL INFORMATION: This is a 14-year-old male with headache and left jaw pain.

FINDINGS: The axial image (figure 1) demonstrates a 4 cm. mass centered in the left parapharyngeal space. It deforms the left nasopharyngeal wall, but the fat plane between the nasopharyngeal wall and the mass indicates that the mass did not arise from epithelium there. The mass extends anteriorly through the pterygopalatine fossa to abut the posterior wall of the maxillary sinus (arrowhead), but it does not appear to invade the sinus. The mass extends laterally adjacent to the neck of the mandibular condyle (large arrow). It is separated from the deep lobe of the parotid by the deep branch of the facial artery. The mass is separated by fat from the internal jugular vein (open arrow). It abuts, but does not encase the internal carotid artery (long arrow). The coronal image (figure 2) demonstrates the mass effect of this large lesion (large arrow). Though the mass lies adjacent to the foramen ovale (small arrow) and appears to engulf an exiting branch of the mandibular nerve, it does not extend intracranially. The mandibular division of the fifth nerve lying just above the foramen ovale is shown on the normal right side (curved arrow).

COMMENT: MRI clearly demonstrates the size and extent of the mass in this difficult location. CT does not provide the multiplanar capability and soft tissue detail afforded by MRI which provides complete presurgical staging and analysis. The differential diagnostic possibilities must include juvenile angiofibroma because of the patient's age and sex. Paraganglioma and schwannoma were also considered possibilities. Mixed tumor arising from the deep lobe of the parotid could produce this appearance, but the lesion appeared to be separate from the deep lobe. The biopsy diagnosis was "sarcoma". Rhabdomyosarcoma in this area more commonly occurs in younger children.

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Is It Ethical To Provide Futile Care?

Kathy Kinlaw

It is a common hospital scenario these days. Faced with new, acute, perhaps life-threatening information about a patient who is unable to make his or her own decisions, a family member (or other surrogate decision maker) indicates that the physician should "do everything." The physician is left with this ill-defined order which implies that all available technology is to be used. But the physician may not agree that using all available technology would be of potential benefit or in the patient's best interests. The patient, family, physician, and other members of the health care team find themselves in a quandary.

The above scenario has many dimensions. First, a significant, life-changing event has occurred in the patient's and family's life. Suddenly a stroke, a cardiac arrest, the birth of an extremely low birth weight infant, or diagnosis of end-stage cancer has changed their status. Strong psychologic factors may underlie this new place and influence decision making. In the midst of guilt, shock, and disbelief, the family's erring on the side of maintaining life is certainly understandable. Second, the physician might well wonder how informed the family really is. For example, when the DNR status was discussed and refused, did the family really understand what would happen in the course of a code? Third, what personal value system did the physician bring to the decision table? How did this impinge on his or her evaluation of the effectiveness or potential benefit of the treatment? Fourth, has a *decision* really even occurred? Would the family or the physician be willing to take clear responsibility for the solution "do everything" or did the very existence of the technology simply imply its use?

The specter of suffering for a child for whom death is certain must be a factor in defining as futile treatment procedures that merely prolong the time until death.

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Defining Futility: The Example of Neonatology

A number of articles in the recent medical literature raise the issue of futility. What is the obligation of the physician to provide or even offer treatment which is felt to be of questionable benefit to the patient?

A. Survival

The final "Baby Doe" regulations (P.L. 98-457) published in April, 1985, warn against the withholding from an infant of any "medically indicated treatment." Exceptions to those requirements include treatments that would be "*futile* in terms of survival of the infant."[1] *Futility* as

used here implies treatment that would not be effective in leading to the infant's survival. But even this definition of futility is not without problems.

Do the Federal Regulations imply ultimate, long-term survival or simply survival at this time? Does treatment that results in a *lengthening of an infant's life* for 1 week constitute successful, non-futile treatment? How about 24 hours . . . 1 hour . . . 20 minutes? Drawing a time line becomes very difficult especially as the quality of that time may have very different valuations for different members of the decision-making team. When intervention allows a family time to bring in siblings to visit the dying child or a minister for baptism, that time span may bear quite a different definition.

Another way of phrasing length of survival time, the "prolongation of dying," has more disturbing implications. In December, 1989, the Pediatric Department at Case Western reported a study comparing neonatal mortality and morbidity for extremely low birth weight infants (< 750 grams) between two time periods: July 1982-June 1985 and July 1985-June 1988. The findings of this one study were auspicious: "Despite more aggressive treatment, *survival* did not change, although the *mean time to death* among infants transferred to the neonatal intensive care unit increased from 73 to 880 hours."[2] One would be hard-pressed to celebrate a "prolonged dying process" in an NICU where respiratory distress syndrome, intravenous fluids, intraventricular hemorrhages, septicemia, changing lines, constant activity, and bright lights prevail. The specter of suffering for a child for whom death is certain must be a factor in defining as futile treatment procedures that merely prolong the time until death.

B. Extent of Effectiveness

If one therapy is futile in terms of survival, short-term or long-term, what of other more basic treatments that are effective in leading to their current, narrow goal but are ultimately futile? Are we not obliged to act responsibly by eliminating them as well? For example, CPR if successful would not be effective apart from underlying therapies such as ventilator support, intravenous feeding, dopamine administration, etc. Thus, if CPR is determined medically to be futile in terms of saving a deteriorating child and the child's death is imminent, one might also question the continuation of the other underlying therapies mentioned above, for they too will eventually prove futile in terms of the infant's survival. (The federal regulations mandate, however, that nutrition, hydration, and medications be given. No clear ethical rationale for this requirement is provided.)

The original meaning of extraordinary care had nothing to do with the degree of technology involved or even the degree to which the practice was accepted in the specialty. Rather, care was considered extraordinary if it led to a greater proportion of burden than benefit for the patient.

C. Quality of Life

Morbidity concerns point to another understanding of futile treatment, that intervention which leads to a *poor quality of life.* A study published in July, 1990, from the University of Washington in Seattle reported a decrease in mortality rates for newborns weighing less than 800 grams between two time periods, but an increase in severity of handicap among survivors in the second period.[3] Is treatment that sustains organic life for a child but carries a strong probability of associated moderate to severe mental retardation, cerebral palsy, and perhaps other handicaps, a treatment one would claim to be successful? . . . or futile? And what of the suffering that a severely affected infant will experience early in the course of treatment as well as in long-term, follow-up care?

Quality of life determinations have two major critiques. First, *predicting* the degree of severity is quite difficult. As greater experience is gained in working with affected patients, statistical predictions of the degree of expected major central nervous system problems may improve but individual exceptions are always possible. And the hope that this child will be the exception, the miracle, is a normal part of families' "coming to terms" process but may also lead many families to anticipate the future unrealistically.

Second, some families, based on their own personal value system, support aggressive measures for their child no matter what the outcome. They hold a *duty-oriented sense of what is right or good* that calls them to claim, care for, and love their child no matter how severely affected. Such a duty may be based, for example, in strong religious beliefs. Other families simply want a child to care for and to love no matter how that child is handicapped. (This rationale, of course, raises other questions about what might be right for the child quite apart from the family's needs. Maintaining a clearly suffering child because of a family desire to have a child is certainly problematic.)

D. Extraordinary Care

Much of what occurs on a daily basis in neonatal intensive care units has been called extraordinary or heroic care. Beyond those slightly

premature infants whom we can support without introducing significant other risks, much of neonatal care is an art rather than a science of *knowing* what the right next step should be. Is providing aggressive treatment for the extremely low birth weight, early gestational age infant in whom outcome (in terms of mortality and morbidity) is still so questionable an ethical response? Acknowledging that much of the progress that has been made in our knowledge of the newborn has been gained through the creative trying of new and newly-applied therapies, are aggressive efforts the fitting response for the individual infant at whose bedside we stand?

Good ethical practice is always based on good communication. Physicians use their time with families wisely by keeping families informed about the patient's current condition and expected prognosis.

The traditional, historic understanding of extraordinary versus ordinary care may be of help. The general perception today of extraordinary treatment is that treatment which involves high technology intervention beyond the recognized or accepted everyday practices in that field of medicine. Thus, in the neonatal field, we might think of ventilator support qualifying as extraordinary care versus incubator warmth and hydration and nutrition. But the original meaning of extraordinary care had nothing to do with the degree of technology involved or even the degree to which the practice was accepted in the specialty. Rather, care was considered extraordinary if it led to a *greater proportion of burden than benefit* for the individual patient. Even nutrition and hydration were considered optional treatments if their use did not lead to a greater measure of benefit versus burden to the patient. Following this understanding, a recent case in which parents asked the physician to discontinue artificial hydration and nutrition of their child dying with short gut syndrome would seem to call for termination of those therapies. The feedings were extraordinary in that they were futile in terms of the ultimate survival of the child, were prolonging the dying process, and possibly lengthening the time of suffering for this child. The burdens outweighed the benefits.

This distinction provides another working definition for futile treatment: that "care" which causes more burdens than benefits for the patient. I would submit that it is not ethical to provide such futile treatment.

Who decides when the burdens outweigh the benefits for a specific patient who cannot speak for himself? The current ideal of decision making as a joint venture between the medical team and the *informed* family is a sound methodology. Neither the physician nor the family has the right to make unilateral decisions. Physicians have had to respond to this limitation as patient autonomy has been emphasized in the 1980s. A similar recognition of limits on families' unilateral decision-making power may now be needed. Families' participation in continuing treatment decisions for patients should not evolve into a relativism in which each and every situation could have a different interpretation ethically according to the particular family's wishes. There are some normative standards that each specialty is called upon to begin defining; there are limits to what choices are medically acceptable in a given situation. These limits are at least partially defined by the benefit/burden to the patient criteria discussed above.

Does treatment that results in a lengthening of an infant's life for 1 week constitute successful, non-futile treatment? How about 24 hours . . . 1 hour . . . 20 minutes?

Part of the charge to medical caretakers is to both help define limits to the choices and to make families aware of how these limits have evolved. Good ethical practice is always based on good communication. Physicians use their time with families wisely by keeping families informed about the patient's current condition and expected prognosis. When families know that the medical team is willing to be open about what options are being considered, a trust relationship develops and a physician's recommendation of the medically acceptable option or options can be heard. The process is one of caring for the whole family, respecting their status as co-decision makers, and yet acknowledging that the right to make decisions implies a clear responsibility (for both physicians and family members) for decisions made. Within this process, physicians should be willing to make a clear recommendation against continuing or initiating care which they consider to be futile.

Is this not simply a new attempt to justify the paternalism that characterized the pre-respect for autonomy and pre-dissipation of medical authority reasoning that marked much of medical history? I think not. Respect for autonomy does not equate with a renouncing of the physician's responsibility in the de-

Respect for the patient demands that the patient's best interests be the central focus; the patient's life should not be maintained solely for the benefit of the family, medical staff, or society at large.

cision-making role. The liability environment today does not diminish this fundamental medical duty. Families do look to the medical team for a certain level of expertise and a willingness to give carefully considered counsel. Again, the onus is on the medical expert to communicate honestly what is known and what the limits of medical intervention, as we presently know, it are. Only fully informed families are truly able to participate in decision making.

There will be occasions even after effective communication and an appropriate amount of time to process a difficult decision, when the family continues to insist on aggressive intervention which the physician considers futile. The judicial precedents in this situation are few and reactionary; when families are *for* aggressive treatment, the court will usually support the preservation of life. Physicians are then forced to decide whether they can continue accepting responsibility for treatment with which they ethically disagree or whether they will discuss with the family the possibility of finding another physician who can both adequately care for the patient and respect the family's pro-treatment wishes. Given an ongoing commitment to working with and informing the family, however, the physician can help keep these impasses to a minimum.

Neither medicine as a whole nor individual physicians should be held hostage to existing medical technology. The technology should exist to *serve* patients and caretakers. To reiterate a theme discussed by Karl Barth, Paul Tillich, and James Gustafson among others, "life is not an absolute good." Organic, biologic life of any duration ought not to be maintained when that life has no or little potential for current or future benefit. Respect for the patient demands that the patient's best interests be the central focus; the patient's life should not be maintained solely for the benefit of the family, medical staff, or society at large. Indeed, it becomes socially responsible to claim the limits to our own human abilities to maintain life and to respect the wise use of limited resources in the process. The willingness to claim responsibility for our decisions about futile treatment discloses eloquently who we consider ourselves to be in our roles as medical servants and stewards.

The willingness to claim responsibility for our decisions about futile treatment discloses eloquently who we consider ourselves to be in our roles as medical servants and stewards.

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Ethical Issues of Cost in Long-term Care

John Sterling Shuttleworth

CAREGIVERS ARE LINKED in providing both care and decision making in placing and caring for an elder in a long-term facility. This linkage can be described as the caregiving triad. A significant decision making aspect in placement is cost. We should, however, consider the deeper or further ramifications of this decision making aspect as it relates to the ethics of cost.

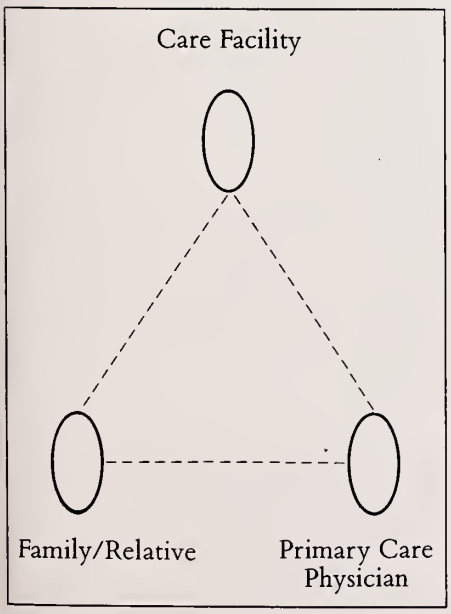

Figure 1. The Care Giving Triad

It is a premise of this commentary that the ethical issue(s) relating to cost are not singular or unitary to one member of the triad, but must be shared by all.

The majority of personal, business, and professional decisions are based upon cost. Webster defines cost as the "pricing of or being priced" of something or item. Economists explore the indirect as well as the direct components of cost. In relationship to the caregiving triad, cost takes on the connotations of both monetary aspects and more intangible aspects. Further, as the decision-making process evolves relative to the initial placement of an elder into a long-term care facility, and the subsequent ongoing care of the elder, the ethical issue of cost confronts the caregiving triad in the form of the issues or questions to consider?

How can we afford mother's long-term care with only her Social Security and Medicare? We do not have the ability to provide the money.... Reimbursement is not meeting the cost for the facility. Staffing demands are too high as an expense; we must reduce cost.... We need to stabilize and treat the resident/patient's anxiety, but she has other more immediate problems. Let's prescribe.... Also, we do not see a need, at this time, for any tests relating to the resident/patient's anxiety....

From this scenario, the potential ethical issues relative to cost evolve. What price does the caregiving triad place on providing the ultimate

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quality of life to and for the long-term care? Further, what cost or price in time, stress, or ability to cope does the caregiving triad accept in providing care for the long-term resident to meet the ultimate quality of life?

We, as products of a cost-based society, all too often render our decisions to the bottom-line. In the caregiving triad, our decisions many times take the path of the lowest cost: failure to work through the imprecise and imperfect funding methods of long-term care; the failure to consider whether institutionalization provides quality of life for the recipient, or are other regimes of treatment better or because of lack of cost reimbursement not acceptable.

As imprecise and elusive as the cost/ethical issue may be to the caregiving triad, there are some potential measures which can be helpful in reducing the judgmental dilemma.

In these various decision making areas, the standards of conduct used to make moral judgments are triggered. The questions becomes cost versus moral judgment. Ethical issues do not lend themselves to empirical studies, but more heuristical methods in problem solving. As imprecise and elusive as the cost/ethical issue may be to the caregiving triad, there are some potential measures which can be helpful in reducing the judgmental dilemma. An interactive paradigm incorporating commitment and resource allocation could be established for the triad.

Such a paradigm lends itself to the triad being able to face some of the issues of standards of conduct and judgmental factors that related to cost. Through the use of the paradigm, it may reduce for each caregiver the stress associated with the dilemma of a judgmental crisis.

Method

The subjects in the triad are the family relatives of elders facing long-term care, care facilities providing long-term care, and the medical professional generally responsible for primary care. Aging, relative to cost, presents concerns to elders and caregivers alike per a study undertaken by Newman et al.[1] Although their study concentrated on the mental health of residents, it also discussed the imprecision of the funding system available to the majority of elders in long-term care and the implications of concerns raised. Further, attitudes toward aging, including cost as a factor, have an effect on the adjustments that the elderly have to make.[2]

The potential cost/ethics dilemma that the caregiving triad faces begins with a catastrophic event occuring in the elder's life: a medical incident such as heart attack or broken hip; the loss of spouse; and/or a quick decline in mental capacity. The family member/relative of the triad is the first to wrestle with the ethical issue(s) of cost.

The literature is well documented that elders seek autonomy both economically and in their emotional and physical well-being. The "major catastrophic event" changes that autonomy in many ways. The cost burden, both monetarily and emotionally, falls on the family/relatives.

At a given point in time, the family/relatives must judgmentally make decisions to evaluate cost, in terms of funds available, and stress in their lives in placing the elder in a long-term care facility.

In the "coping-stress" study cited in Gratz,[3] a model was constructed that family caregivers face the potential ethical cost dilemma and ultimate quality of life of elder.

The care giving triad consists of the relatives of elders facing long-term care, the long-term facility itself, and the medical professional generally responsible for primary care.

The second member of the triad is the long-term care facility. The majority of funding for long-term care is supplied through the federal government under Medicare and Medicaid and is administered by the Health Care Financing Administration (HFCA). Long-term care funding is not uniform from state to state, and the facility/provider must "cost-in" the line items of room, board, health care services, nursing services, and etc. Generally all are costed as a function of per bed cost, i.e., relating to skilled care, intermediate care, and/or ordinary care.

Cost takes on several ethical aspects: potential control of residents, i.e., minimum number of employees necessary to control residents and structural layout relating to maximum space at minimum cost.

Whether a "for profit entity" or "not for profit entity," administration faces the cost/ethical issues. Judgments must be made constantly over cutting the highest cost of operations — employees (professional and non-professional). This costing judgmentally focuses

on the ultimate issue of providing quality of life for the resident.

The third member of the triad is the primary care physician. Elders have a myriad of medical problems. In addition, elders have mental health problems which require, at times, significant tests and evaluations from other health care professionals.

The pressures of time allocations, the priority of medical needs, the imprecise mechanism of funds available, and the complexities of mental health problems sometimes place the primary care physician in a cost ethical dilemma which has manifested itself in the more liberal use of anti-psychotic drugs as a means of reducing anxiety, depression, and other mental health symptoms of the elder residents.[4] As documented, HCFA has questioned this procedure and established new guidelines relating to use of anti-psychotic drugs in nursing homes effective October 1, 1990.

The question for the primary care physician in cost ethics relates to: does stabilization as a tenent of quality of care meet the ultimate quality of life aspects for the elder resident/patient?

Discussion

Although we have touched on some specific ethical/cost issues facing each member of the caregiving triad, there is also an interrelationship which is present, each adding to or reinforcing directly or indirectly the judgmental aspects of cost, the bottom line of what is provided to and for the elder resident. This interrelationship can best be discussed by a hypothetical example:

The family caregiver no longer believes he or she can handle the cost of letting the elder remain outside a long-term care facility. Further, due to the nature of the physical problems, the elder is anxious. The elder is placing stress on the family. The family asks the primary care physician to calm the elder down.

The long-term care facility accepts the elder but finds there is only a short-term amount of private funds that the elder has available, only Medicare/Medicaid. Here to the elder in question, once placed in the home, manifests more anxiety.

The facility's nursing staff and administration become concerned. They also seek a method of stabilization, i.e., control of the elder through the prescribing of drugs by the primary care physician.

Judgments must be made constantly over cutting the highest cost of operations — employees. This . . . focuses on the ultimate issue of providing quality of life for the elder resident.

The elder's mental health symptoms are rather general, anxiety and some periods of depression. Due to time pressures and funding of tests, a wait and see attitude is established with the elder remaining on anti-psychotic medication.

In essence, all members of the triad enhance the justification, the judgmental process, the cost related to the care and treatment of the elder. It is a premise of this commentary that the ethical issue(s) relating to cost are not singular or unitary to one member of the triad, but must be shared by all. No one member of the triad is the policing entity for the triad.

As discussed earlier, an interactive paradigm should be established which may be helpful in reducing the dilemmas arising relating to cost/ethics questions of the caregiving triad.

Four aspects should be included in such a paradigm:

1. Specific methods of cross communications between and among members.
2. Pre-planning and cost review, including avenues of funding to meet the elder resident's abilities and needs.
3. Reviews of what each caregiver within the triad can realistically provide in time and resources.
4. A resource allocation commitment agreement should be executed by each caregiver for a specific resident as an integrated plan.

Clearly, the issue(s) of ethics and cost are imprecise and difficult to quantify. The future, as it relates to caregiving for the elderly and cost, will come about more positively through better communication within the caregiving triad. Some of the ethical questions can also be answered through education.[5] It behooves all members of the triad to consider these matters for the ultimate quality of life for the elder/aged resident.

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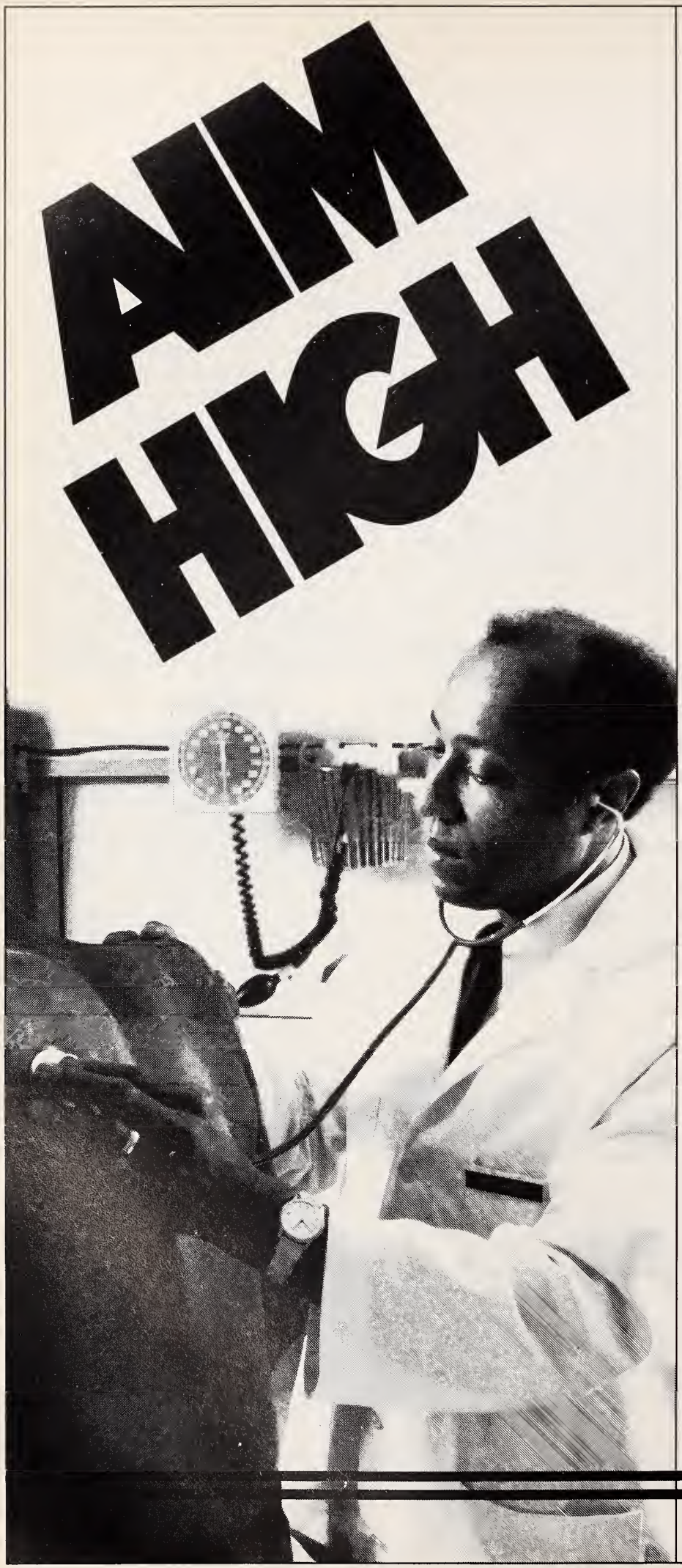

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An Ethical Dilemma: Public Safety or Personal Privacy in Reporting HIV Infection

Bruce M. Whyte, M.D., Joe Geoffrey, M.S.W., Joseph A. Wilber, M.D., Jane C. Carr, R.N.

Due to the anonymity of reporting of HIV infection in Georgia, as required under Act 1440, it is not possible to exclude duplicate reports or repeat positives.

SINCE JULY 1, 1988, persons in Georgia infected with HIV have been required to be reported to the Georgia Department of Human Resources (DHR). Concern has been expressed that data from these reports are unreliable and do not allow differentiation between individuals. In addition, as reports are anonymous, tracing of sexual and needle sharing partners is not possible. Increasingly, attention is being focused on the need to require reporting of HIV-infected persons by name in order to redress these concerns. This paper considers all aspects of reporting, including data from states already requiring reporting by name.

Surveillance of Infectious Diseases

The two principle cornerstones of public health responses to an infectious disease outbreak, including individual management, are surveillance of the disease and tracing of associates or contacts of the index case. Surveillance is the systematic collection of data about each case of the disease of interest. There are four primary objectives of surveillance:

1. To understand the spread of the disease, including incidence, prevalence, trends;
2. To target effective preventive efforts;
3. To assist in planning for future resources, including personnel, therapies; and
4. To provide information for society.

Traditionally, surveillance has relied on reporting (notifying) of cases by physicians and clinics to appropriate public health offices. Usually, this is a legally required procedure in which the specific details of information to be reported are not included within the legislation but left to the discretion of the public health officials. A standardized case report form is produced to collect these data which are collected, analyzed, and interpreted by the public health office.

Contact Tracing

As a consequence of reporting a person by name with a reportable infectious disease, persons who associate with that person (contacts) can be identified by public health staff. These may be sexual partners (for sexually transmissible diseases), household members (for diseases transmitted through other close contact), needle sharing partners (for parenterally transmissible

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diseases), or any combination of these. Appropriate curative or prophylactic therapy can be provided and information provided to these contacts about limiting further spread. In many instances, contacts are not aware of the risk of disease to which they have been exposed and contact tracing provides the opportunity to minimize further morbidity.

Reporting of Infectious Diseases in Georgia

A total of 41 infectious diseases are required to be reported in Georgia to the Office of Epidemiology and the Office of Infectious Disease (OID). Of these, 39 are reported using a Weekly Morbidity Report form produced and distributed by DHR. In all these reportable infectious diseases in Georgia, the name of the infected person has been one required piece of information. This is necessary in order that duplicate reports can be eliminated and for contact tracing to be performed. AIDS is also reported to DHR on a confidential case report form produced by the Centers for Disease Control (CDC) which contains, among other data, the name of the individual (kept at the state office but not transmitted to CDC). A separate form, produced by OID, is used for reporting individuals infected with HIV who have not been diagnosed with AIDS. It is only on the latter report form (that for HIV) that no information is collected that could lead to identification of the individual or allow elimination of duplicate reports. This is a result of the Georgia Omnibus AIDS Legislation, Act No. 1440.

HIV Reporting Requirements in Georgia

Infection with HIV became a reportable condition in Georgia on July 1, 1988, under provisions within Act No. 1440 (House Bill No. 1281). The relevant section of the Act states: *Each health care provider, health care facility, or any other person or legal entity which orders an HIV test for any person shall report each confirmed positive HIV test to the department along with age, sex, race, and county of residence of the person having the confirmed positive HIV test but shall include in that report no other identifying characteristics regarding the HIV infected person....* These strict requirements were instituted to protect the privacy and confidentiality of infected persons.

As a result of the protection of anonymity in Georgia, it is not possible to distinguish individual persons from individual reports when there may be multiple reports on the one individual. As a further consequence, contact tracing performed by public health staff is not possible, as there is no method of obtaining the name of the index case from the report and from whom the names of the contacts could be ascertained. Only if the infected person requests assistance in counseling their contacts, and in so doing provides their names, can public health personnel perform contact tracing.

However, the Georgia Omnibus AIDS Legislation authorized DHR to amend the reporting and require reporting by name if deemed necessary.

National Guidelines on HIV Reporting

The federal government cannot and does not require mandatory reporting of any disease. Hence, CDC had not required reporting of AIDS or other HIV infection but has encouraged reporting of AIDS and has developed a standard case report form and appropriate computer software. Reporting of HIV has been discussed by CDC with the states and the advantages of collecting data in a standardized manner outlined. A workshop on Standardization of HIV Reporting, held in early 1989 by CDC with 16 states, developed the following recommendations:

1. States requiring reports of HIV infection with or without personal identifiers should collect a minimum set of information to allow comparison of data beyond the state level. Reports should be collected in a manner that allows repeat positive reports to be excluded;
2. Data collected for HIV infection reporting (e.g. risk factor) should be consistent with data collected for other HIV activities such as AIDS case reporting and results from counseling and testing sites;
3. HIV infection reporting should be accompanied by appropriate safeguards for confidentiality to protect the individual and to reduce the potential negative impact on participation in voluntary counseling and testing activities;
4. CDC should collect summary data without personal identifiers and disseminate on a regular basis a minimum set of data from states with mandatory and voluntary reporting of HIV infection. These data should include age, sex, race/ethnicity, state of residence, and if possible, transmission category and clinical status. These data should include only reports on persons with appropriate supplemental testing. A concerted attempt should be made to exclude repeat positive tests and reports. These data should be reported in a standardized format to allow comparisons over time and between areas; however, distinctions in methodology by state (e.g., reporting with or without names) should be carefully noted;
5. HIV infection reporting should not interfere with AIDS case reporting or seroprevalence surveys. AIDS case reporting and seroprevalence surveys should be the primary means by which trends in incidence of HIV infection in the United States are followed; and

6. HIV infection reporting needs to be evaluated rigorously to determine its usefulness in prevention programs and in monitoring trends. This evaluation should be conducted jointly by the states and CDC.

The Council of State and Territorial Epidemiologists (CSTE) adopted in mid-1989 a policy similar to that of CDC. However, CSTE also recognized the limitations imposed by resource requirements in implementing reporting and including contact tracing. A supportive approach was adopted in March 1990 by the Committee on Human Retrovirus Testing of The Association of State and Territorial Public Health Laboratory Directors (ASTPHLD) . . . *good laboratory practice requires that a discrete patient identifier be provided to the laboratory with each specimen submitted for retrovirus testing. For public health purposes, age, sex, disease status, ethnic origin, risk group and special circumstances (such as blood bank origin) should be included on the test request form.*

Protection Against HIV Discrimination in Georgia

Unlike other states, e.g., Florida, Massachusetts, and North Carolina, Georgia does not have a law which specifically forbids discrimination against HIV-infected persons. Below are listed some of the federal and state laws which offer some protection.

1. Georgia Handicap Law: Protects handicapped persons in both the public and private sector. However, it does permit an employer to inquire about an applicant's handicap and to make employment decisions based upon disclosed information. Official Code of Georgia Annotated, 34-6A-3, *Nothing in this chapter shall be construed to prevent an employer from making any job related inquiry about the existence of the handicap of an applicant for employment and about the extent to which that handicap has been overcome by treatment, medication or other rehabilitation.* Further the employer is not prohibited from rejecting an applicant for employment on the basis of *any communicable disease, either carried by or afflicting the applicant.* This definition of "communicable disease" as it applies to AIDS in the work place has not yet been tested in court.
2. Section 504 of the U.S. Vocational Rehabilitation Act of 1973: This federal law prohibits discrimination against qualified handicapped persons in federally funded programs and contractors. Coverage for many areas of the private sector is thus limited. In October 1988, the U.S. Attorney General ruled that this law also offered protection to people who are HIV infected or perceived to be infected.
3. Employee Retirement Income Security Act (ERISA) of 1974: This U.S. law applies generally to all employee benefit plans maintained by employers in the private sector, including pension, life insurance, and medical benefit plans. Under Section 510 of ERISA, an employer may not discharge, suspend, or discriminate against an employee for the purpose of depriving that employee of benefits to which the employee is entitled or may become entitled. For example, an employer could not discharge a sick employee just to save on health insurance costs.
4. The Americans with Disabilities Act (ADA): This federal legislation has passed both houses of Congress, but with different language in each house. The bill is similar to Section 504 of the U.S. Handicap Law, but ADA also applies to the private sector that does not receive federal funding. Discrimination by employers, public service companies (buses, rail lines, public transportation, etc.) and businesses established for the public and whose operations affect commerce, would be forbidden. This bill was signed into law in July 1990 by the President but would not become effective until 1992 for businesses with more than 24 employees and in 1994 for businesses with more than 14 employees. However, small businesses (those with fewer than 15 employees) would be exempt. The ADA goes a long way in providing protection in the work place and in public accomodations, but it does not provide the comprehensive protection afforded minorities under Title VII of the 1964 Civil Rights Law.
5. The Fair Housing Amendments Act: This federal legislation prohibits discrimination against persons with all stages of HIV infection in the sale or rental of housing. This is an extension of existing protection for people with disabilities and is supported by regulations with the Department of Housing and Urban Development.

Unlike other states, e.g., Florida, Massachusetts, and North Carolina, Georgia does not have a law which specifically forbids discrimination against HIV-infected persons.

Reporting of HIV Nationally

As of June, 1990, 32 states had legally required reporting of HIV infected persons, five had encouraged voluntary reporting, and two required reporting only of symptomatic HIV infection (Figure

1). Several were in the process of introducing legislation requiring reporting of HIV-infected individuals. Of those 32 states, 22 require reporting using the name of the infected person, but in three of these, the reporting system was not yet prepared and therefore not operational. However, of the 19 states that have commenced reporting by name, only six provide solely confidential testing using the individual's name and are thus able to clearly exclude duplicate reports. The remaining 13 states offer both confidential and anonymous testing (Table 1).

Data from several states indicated that there was not a universally accepted definition of an HIV-infected person. Most states require both repeatedly reactive enzyme linked immunosorbent assays (EIA) and a reactive supplemental test, usually western blot (WB). However, at least two states define HIV infection solely on the basis of a

TABLE 1: Requirements for Reporting of HIV by Name and Criteria for HIV Infection, August, 1990

			REPORTING SOURCE			*POSITIVE CRITERIA*				
State	*Effective Date Report*	*Anonymous Reporting*	*MD*	*Lab*	*Other*	*EIA Only (1)*	*WB/ IFA Only (2)*	*Antigen/ Culture Only (3)*	*(1&2)*	*(1&3)*
States with solely confidential (named) reporting										
Alabama	1988	N		Y					+	
Colorado	1985	N	Y			+	+			
Idaho	1987	N	Y	Y					+	
North Dakota	1988	N	Y	Y	Y				+	
South Carolina	1986	N	Y	Y	Y		+	+		
South Dakota	1988	N	Y	Y	Y				+	
States with both confidential and anonymous reportings										
Arizona	1987	Y	Y	Y		+	+		+	
Arkansas	1988	Y	Y	Y	Y				+	
Minnesota	1989	Y	Y	Y	Y				+	
Mississippi	1985	Y	Y	Y	Y	(+)			+	
Missouri	1987	Y	Y	Y	Y				+	
Oklahoma	1988	Y	Y	Y		(+)			+	
Utah	1989	Y	Y	Y	Y	(+)			+	
West Virginia	1988	Y	Y	Y					+	
Wisconsin	1985	Y	Y	Y					+	+
Wyoming	1989	Y	Y	Y					+	

New Jersey — legislation initially passed but is being reconsidered.
Ohio, North Carolina — not yet operational.
(+) Although reported, confirmatory testing is required before inclusion as a case.

reactive EIA (AZ, CO) (Table 1). Three other states (UT, MS, OK) require an individual to be reported on the basis of a single positive EIA only, although further investigation must be performed to confirm or refute this result. Until confirmed by an alternative technique, these persons are not included in the HIV statistics.

Consensus between experts at national meetings convened specifically to consider deriving estimates of the prevalence of HIV infection in the USA suggests that approximately 1,000,000 Americans are infected with HIV, including those with AIDS. There were 117,754 individuals reported with AIDS nationally through 1989 which leads to a ratio of HIV-infected individuals to AIDS of 8.5:1.

The 22 states with mandatory reporting of HIV by name, including those without an established system for reporting, accounted for only 20% of reported AIDS cases in 1989. If New Jersey revises their legislation and does not proceed with reporting by name, only 14% of reported cases would be represented by the remaining 21 states.

Results of Reporting of HIV in Georgia

Since reporting of HIV infection commenced on July 1, 1988, greater than 10,000 reports had been received to June 30, 1990. Only 8,059 of these have been useful and analyzed, those being reports in which at least four of the required five pieces of data were provided (age, sex, race, county of residence and test results). Some reports have been discarded as duplicates of previously received reports on the basis that some variables matched when compared manually. The remaining reports may contain unrecognized duplicates.

Of all reported cases of HIV infection, 15% (1,183) have been female and 84% (6,766) male (in 1% data were incomplete). In contrast to the male to female ratio of 14:1 in cases of AIDS, the ratio among reported HIV infected persons was 6:1. The mean age of the females was 28.7 years, and 61 were adolescents. The mean age of the males was 30.3 years, and 128 were adolescents. Thus, 189 individuals were adolescents. Blacks account for over 57% of all reported cases, in contrast to that of AIDS cases (40%) and the Georgia population (27%).

Due to the anonymity of reporting of HIV infection in Georgia, as required under Act 1440, it is not possible to exclude duplicate reports or repeat positives. Thus, the number of reports received and included within the HIV database maintained by OID is not reliable or accurate if used as a measurement of the number of infected individuals.

Although some data collected on HIV-infected persons are comparable with those on persons with AIDS or those being tested at counseling and testing sites (age, sex, race, county of residence), additional data about risk activities or clinical status are not sought. Under the current legislative guidelines, it is not possible to collect these additional data. Precise targeting of behavior specific preventive efforts is thus difficult as is planning for health care resources.

There are no regulatory controls over testing for HIV antibodies in laboratories in Georgia and no mechanism for estimating the extent of testing for HIV. Data are available from the public health laboratories, which show that 125,316 specimens were tested for HIV between 1985 and March 1990, of which 7,529 (6%) were infected. It should be noted that these were specimens and not necessarily individuals. Comparable data are not readily available from private laboratories.

In order to assist in determining if these reports represent the true prevalence of HIV-infected persons in Georgia, use of data from the Household Family of Surveys (HFS) of HIV seroprevalence can be extrapolated to the population. The statewide seroprevalence of HIV in newborn infants in a 6-month period in 1988-1989 was 0.17%. This represents 17 infected women in every 10,000 women or 2,600 infected women in Georgia if applied to the total female population aged between 15 and 45 years (this assumes that these data can be generalized to this population, a questionable assumption).

Testing of women at family planning clinics and abortion clinics in Atlanta over a similar period of time as the newborn screening found an average seroprevalence of 40 infected women in every 10,000 regardless of site. If this is extrapolated to all women in the state aged between 15 and 45 years (using the same assumption as above), it results in about 6,000 HIV infected women.

Testing of women at STD clinics in three Atlanta counties found an average seroprevalence of 120 HIV infected women per 10,000 women. This extrapolates to about 18,500 HIV-infected women statewide aged between 15 and 45 years. This is an overestimate, as attendance at these clinics is based on the premise that activities at high risk for HIV infection have been practiced.

Use of data from women tested in Atlanta would appear to be valid when extrapolated to areas of Georgia outside Atlanta if cases of AIDS in women are a reliable index. The number and characteristics of women with AIDS in metropolitan Atlanta were the same as those in women living outside Atlanta for those reported to December 31, 1989.

Obviously these results are biased by a number of factors, including geographic site of testing, type of clinic chosen, and female popula-

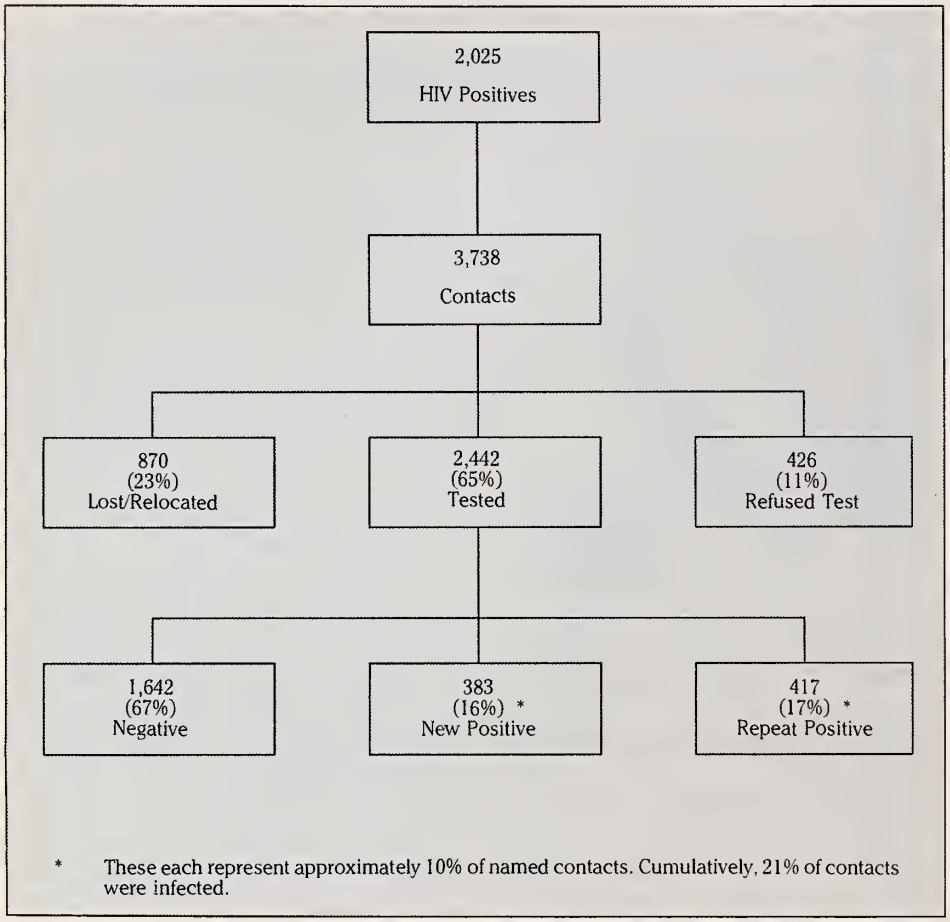

Figure 2: Contact tracing and testing South Carolina, Colorado, Missouri, June, 1990

tion tested. Even considering such biases, the range in the number of young women infected with HIV (2,600 to 18,500 or a seven-fold difference) is excessively large. These estimates, however, are considerably larger than the 1,059 women aged between 15 and 45 years who had been reported to OID infected with HIV to June 30, 1990.

Results of Contact Tracing of HIV Infected Individuals Nationally

Data were provided from only three states about the effectiveness of contact tracing, although a number of other states stated that their program was effective. South Carolina, Missouri and Colorado provided data for 1989 (SC and MO) and 1986-1989 (CO). Over those collection periods, 2,025 HIV-infected persons were identified in health department clinics, and 3,738 partners and contacts were identified for a contact: index ratio of 1.8:1 (Figure 2).

A total of 383 newly identified HIV-infected contacts were identified through counseling and testing and 417 contact persons, previously known to be infected, were confirmed. Thus, 21% of all named contacts were found to be infected with HIV of whom half were newly identified. An additional 1,296 (35% of all contacts) were not tested due to loss to follow-up, relocation, or in the case of 426 (11% of all contacts) refusal to be tested.

Application of these data to the Georgia data (without data to suggest the validity of such an application) would suggest that 16,000 contacts (8,000 × 2) may be identified. Further extrapolation results in 1,600 newly identified HIV-infected contacts and an additional 1,600 previously identified infected contacts. The latter may have been previously reported or may be newly identified to the reporting database.

Implications of Reporting of HIV by Name

Proponents of reporting of HIV-positive individuals by name argue that the person can be referred for health assessment and secondary preventive therapy. At present, approximately 50% of those tested anonymously at publicly funded counseling and testing sites in Georgia return for their results and post test counseling. There are limited resources for management of those who do return.

It is estimated that approximately 10,000 Georgians have tested HIV positive in our state laboratories (anonymous and confidential), of whom 2,500 have no health insurance or other source of payment for health care. Ongoing care for these persons will be a public health responsibility. Approximately 58% of these persons are sufficiently immunocompromised to need medication and medical supervision to delay progression of the disease and prevent opportunistic infections. Prophylactic and curative therapy for *Pneumocystis carinii* pneumonia (PCP) and use of the antiviral agent zidouvine (AZT) for 58% of these 2,500 HIV-infected persons would cost approximately $3,750,000 per year. Medical management of infections other than PCP and other AIDS conditions will substantially increase this cost. Laboratory and medical supervision (in public health clinics) would cost an additional $3,750,000. In addition, it is likely that some of those HIV-infected persons who do have health insurance will seek care from the public sector.

Thus, if reporting by name of HIV-infected persons is instituted in Georgia for the purpose of early diagnosis and treatment, the provision and training of staff and facilities must be simultaneously established for regional public

health infectious disease clinics. It is estimated that the cost of establishing four regional ambulatory clinics for those found to be HIV infected who have no other resource would be approximately $8,000,000 per year. However the delay in progression of the disease and the resulting decreased hospitalization and prolongation of the person's ability to be employed would likely make these clinics cost effective.

Personnel Requirements

The burgeoning syphilis epidemic has already overextended staff responsible for contact tracing. Reporting by name of HIV-infected persons would increase the burden of partner notification and contact tracing by a factor between 2 and 5. Some states believe there are up to 10 contacts for each HIV-infected person, although the data presented here suggest only two.

It is difficult to estimate the number of additional interviewers that would be required for contact tracing of HIV contacts. If data from the Georgia STD Program are used as a basis, it is found that for 7,922 newly diagnosed cases of syphilis in fiscal year 1990, a total of 14,621 contacts were named (contact:index ratio of 1.8:1) of whom approximately one half were located and treated (Figure 3). On an additional 649 contacts, no tracing or interviewing was performed due to insufficient information or relocation elsewhere. There were 2,008 contacts on whom tracing and/or interviewing was performed but no treatment provided. Thus, 9,824 contacts (67%) required time of the interviewers.

In addition, 6,985 individuals with gonorrhea named 3,374 contacts (contact:index ratio of 0.5:1). Due to the excessive caseload on interviewers, gonorrhea cases have been encouraged to counsel their contacts and refer them for treatment. The caseload on interviewers has thus declined over the last year. In this period, there were 20 full time interviewers in Fulton County and 71 part-time interviewers in the rest of the state. Additional assistance was provided by 6 HIV counselors and occasionally by trainee interviewers.

Assuming Fulton County accounts for half the STD caseload, each full time interviewer has 330 contact cases. In other areas, interviewers, who are responsible for other public health responses, have a caseload of 100 contact cases. Assuming a similar geographic breakdown of HIV, contacts would require an additional 23 full time counselors and 77 part-time, approximately a doubling of the current number. For the purpose of cost determination and as the part-time counselors are required to spend between 10% and 50% of their time on STD counseling, these 77 positions could represent 20 full time positions. Thus, 43 new community epidemiologists would be required at a cost of $1,560,000 (personnel services $1,320,000 plus operating, travel expense, and support expenses of $240,000).

Disadvantages of Reporting of HIV in Georgia by Name

The perceived absence of suitable safeguards for protecting the confidentiality of HIV-infected persons does little to encourage testing, especially by persons at higher risk for infection. Although confidentiality of data within OID is protected, it is difficult to protect an individual against discrimination on the basis of activities believed by others to occur. Introduction of reporting by name and the subsequent tracing of contacts would result in considerable additional fiscal

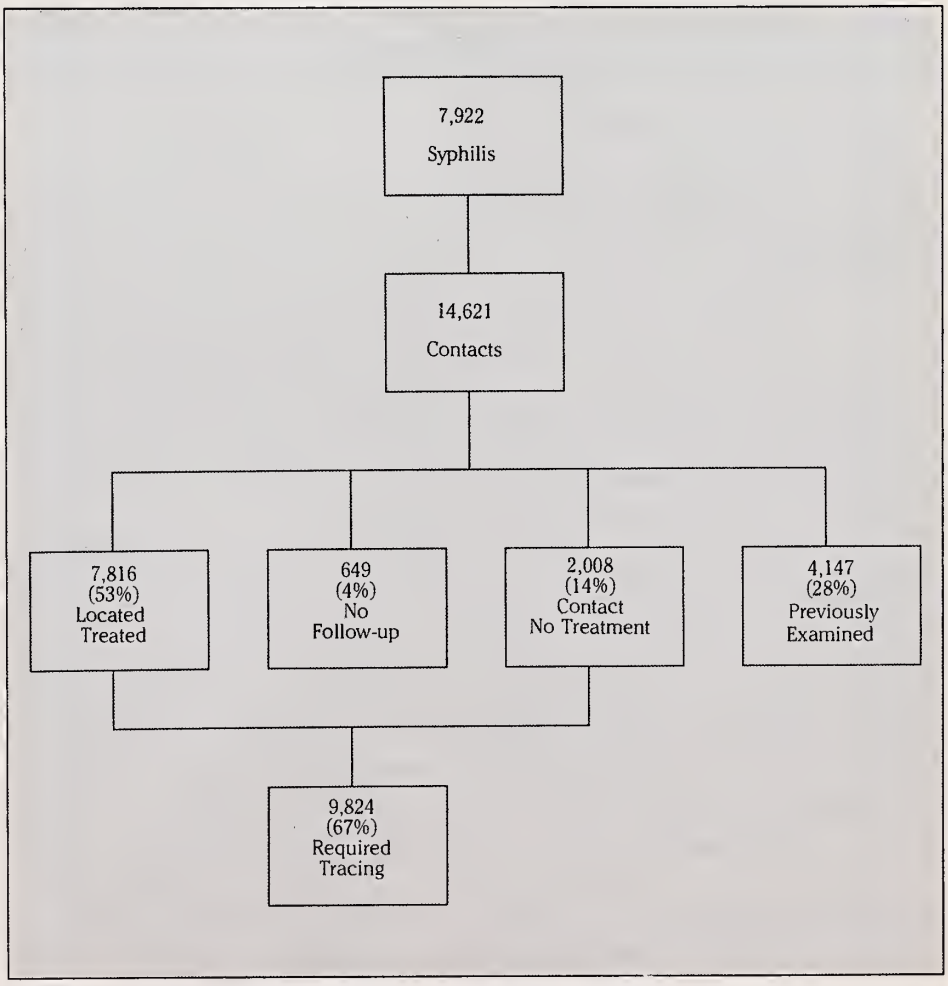

Figure 3: Contact tracing of syphilis, Georgia, FY 1990

expenditure. The estimates presented here are conservative but still total about $17 million, the major portion of which would be required yearly as operating expenses.

Apart from fiscal requirements, additional personnel would be required who would need training and supervision. If these additional counselors cannot be provided, existing counselors and interviewers would be required to increase their caseloads. As their loads are already excessive this would require neglecting other areas of responsibility.

Increasingly, attention is being focused on the need to require reporting of HIV-infected persons by name. This paper considers all aspects of reporting, including data from states already requiring such reporting.

It is assumed that introduction of reporting requirements for any disease will result in a high degree of compliance in reporting by physicians. Data from the US and other Western countries suggest that reporting of many other infectious diseases is only 10%-20% complete. There is no reason to assume that the compliance in reporting HIV infection would be different to that for other less stigmatizing diseases.

Advantages of Reporting by Name

Collection of an individual's name on a report allows minimization of duplicate reports. In combination with other collected data (sex, race, county of residence), exclusion of duplicates is likely to be complete. The resulting number of HIV-infected individuals is likely, therefore, to be an accurate number.

Reporting by name allows public health personnel to reach contacts of the index person and provide both counseling and testing. Thus, not only can appropriate advice and, if needed, medication be provided to contacts, but further spread can potentially be minimized. It has been estimated that the individual fiscal cost of HIV infection can be as high as $1 million, including direct and indirect costs. Thus, any efforts that result in minimizing further infection are likely to be cost effective.

Federal funding for HIV prevention and treatment services is increasingly being linked to numbers of AIDS cases and potentially to estimated numbers of HIV-infected persons.

Alternative Surveillance Techniques

As described here, surveillance of HIV infection relies on reporting of AIDS cases by name and anonymous reporting of other stages of HIV infection. Reports on the latter are received from any provider of health care to those individuals, including physicians and non-medical personnel. There are several alternative techniques that should be considered:

1. *Reporting by name:* The current reporting requirements can be readily amended to require reporting by name.
2. *Restriction of reporting:* Reporting of HIV infection could be restricted solely to physicians. If anonymous reporting was continued, the potential for duplicate reports would be minimized but not eliminated. If reporting by name was required, duplicates would be virtually eliminated.
3. *Sentinel sites:* Elimination of reporting of HIV altogether and the use of selected sites for monitoring trends in HIV infection is a possibility. Use of sentinel sites for this form of monitoring is already used in the US for some conditions, e.g. influenza. Although this technique will allow some monitoring of trends it would not allow incident or prevalent estimates to be generated.
4. *Laboratory surveillance:* Since all HIV-infected individuals are tested for HIV antibodies, use of data from laboratories performing these tests could provide useful estimates of prevalence and incidence. Assuming duplicates could be excluded (use of names on investigation requests or previous testing history and results) prevalence would be simply the aggregation of all individuals testing positive. Use of past testing history and results, with or without identifiers (see ASTPHLD recommendations) would provide incidence estimates. Introduction of this technique would require cooperation of both requesting sources and all laboratories that test samples from Georgia. Much testing is performed in private laboratories located in other states.
5. *Reliance on AIDS surveillance:* Reporting of HIV infection other than AIDS could be discarded and efforts to accurately monitor AIDS cases improved. Reporting of AIDS in Georgia is approximately 85% complete which implies that relatively little may be required to improve this figure. However, since AIDS is a late stage of HIV infection, occurring after an interval as long as 10 years of asymptomatic infection, this would do little to improve understanding of current trends in HIV infection. In addition, as the caseload of AIDS increases, the completeness of reporting is likely to decline.

Conclusion

It is apparent that although reporting of many infectious diseases is an accepted public health procedure, this does not appear to be the case for HIV infection. Intervention and prevention responses to HIV infection are blunted by important issues of confidentiality of patient information, discrimination against those infected and a general paucity of understanding of HIV. Current discussion about reporting of HIV brings to the forefront these issues which have lain dormant since the epidemic began. Confidentiality of a person's medical information, is a basic pre-requisite in clinical medical and public health practice. Although breaches of this confidentiality are rare, the potential for personal harm subsequent to any such breach is sufficiently severe to result in overzealous protection of this information. Efforts to stress and where appropriate strengthen such confidentiality and understanding of HIV and minimize further discrimination must be encouraged.

These issues are applicable in Georgia also. As in other states, additional factors influencing public health management of the HIV epidemic have been lack of effective treatments and stigmatization of sexual practices and drug using behaviors. The prolonged incubation period during which an infected individual is asymptomatic further confuses society. It is the result of these concerns, and not those of political pressure groups, and the need to encourage testing of those individuals practicing high risk behavior that led to the current Georgia reporting requirements.

The effectiveness of this approach is apparent as over 70,000 individuals have been counselled and tested at public health clinics, many of whom acknowledged practicing high risk activities. In addition, many have requested public health assistance in informing their partners. This positive response has been despite active discrimination against some HIV infected individuals in Georgia. If reporting of HIV infected individuals by name commenced and if sufficient and appropriate public health personnel were available, perhaps Georgia is ready to adopt the traditional approach to controlling this infectious disease.

Acknowledgements

This discussion paper was only possible as a result of the provision of information and data from many states and CDC. The authors wish to express their gratitude to all who assisted.

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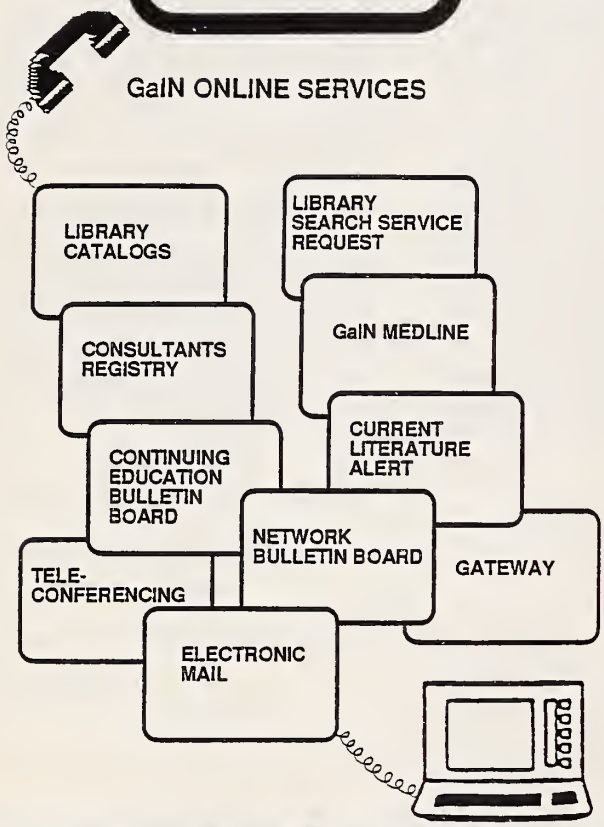

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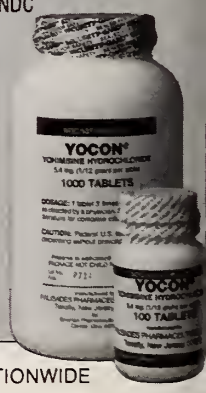

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Setting Limits: *A Provocative Statement of Ethical Principles in Geriatric Medicine*

Herbert R. Karp, M.D.

ETHICAL BEHAVIOR in the practice of medicine has always been of concern to physicians, philosophers, and theologians. Until relatively recently, codes of medical ethics have dealt with direct precepts concerned with the relationship of physicians to patients, to other physicians, and to society in general. Through the centuries, these forthright principles have served as valuable standards of conduct. However, as medicine has passed from being primarily a caring profession, these doctrines are often inadequate to deal with the complexities of the modern practice of medicine. This transition has been abetted by many factors such as advances in medical technology, the economics of medical care, rules and regulations dealing directly and indirectly with the practice of medicine, and the changing expectations of medicine by society, to name but a few. As a consequence, there is a burgeoning body of knowledge which has attempted to provide some rational principles of modern biomedical ethics.

In addition, there has been a tendency to codify the ethical issues in relation to specific biomedical disciplines. Virtually every textbook of medicine has a section reflecting the author's concept of the ethics relating to a specific area of medicine. This trend not-withstanding, most biomedical ethical issues are universal and are pertinent to all fields. Examples of such generic concerns are informed consent and matters related to active or passive euthanasia, such as deescalation and termination of care, and do-not-resuscitate orders (DNR). Other questions such as those related to genetics, abortion, or behavior control, obviously are more relevant to specific specialties of medicine.

"One of the most vexing issues in relation to the older patient is the matter of the *allocation,* or to use a more inflammatory term, the *rationing* of health care. This . . . is the single most important ethical concern facing the medical care of the elderly today."

Some bioethical issues are particularly applicable to geriatric medicine by virtue of the likelihood that they will be encountered in the course of treating older persons. Examples are those related to the physician's responsibility to the hopelessly ill patient. These are presented in an excellent review by a panel of distinguished physicians, chaired by Daniel Federman.[1] Issues discussed by the panel include the settings for dying (home versus hospital versus intensive care unit versus nursing home), and the sensitive and often contradictory ethical and legal precepts which arise in treating the dying patient. The panelists acknowledge the existence of legal concerns, but formulated their ethical conclusions independently of legal decisions. This was stated most forcefully. "The physician should follow these principles without exaggerated concern for legal consequences, doing whatever is necessary to relieve pain and bring comfort, and adhering to the patient's wishes as much as possible. To withhold any necessary measure of pain relief in a hopelessly ill person out of fear of depressing respiration or of legal repercussions is unjustifiable. *Good medical practice is the best protection against legal liability*" (emphasis, the author's). Another general recommendation of this panel is "a sensitive approach to care — one that is adjusted

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continuously to suit the needs of the patient as death approaches."

Other ethical issues which are particularly applicable to the aging patient can be considered under the rubric of "Justice, Social Policy, and the Province of Medicine."[2] Of these propositions, the one that is the most vexing in relation to the older patient is the matter of the *allocation,* or to use a more inflammatory term, the *rationing* of health care. This is in my opinion the single most important ethical concern facing the medical care of the elderly today. The intensity of the reaction to this question stems from one of the most basic tenets of moral behavior which is deeply rooted in the religious and cultural heritage of Western Society — the commandment to honor our Father and Mother. In addition, those who now consider themselves as being young are concerned not only for the welfare of the old but also for the time when they themselves will be regarded as old.

'Callahan's stated objective for his book is "a call for limits, for sobriety of purpose, and for a willingness to ask once again how we might creatively and honorably accept aging and death when we become old, not always struggle to overcome them.'

Daniel Callahan, Director of The Hastings Center, in his book, *Setting Limits, Medical Goals in an Aging Society,*[3] presents a thoughtful and sensitive exploration of the question of the relationship of health care for the elderly to the totality of health care. Callahan presents as a primary thesis that in the 1970s care of the aged became a primary goal of medicine. He also raises the arguable point that medicine has been driven by "a longstanding ambition to forestall death. It (medicine) should give up its relentless drive to extend the life of the aged, turning its attention to the relief of their suffering and an improvement in their physical and mental quality of life."

As medicine has shifted from being primarily a caring profession to being both curing and caring, there have also been fundamental changes in society's conception of health. When viewed from the perspective of the accomplishments in the control of infectious disease and other advances, health has been transformed from being a "nebulous hope to being a fundamental social requirement."

Another interrelated transformation has been in the conception of "what it means to live a life." This encompasses the conviction that one's medical destiny can be controlled by personal health care and taking sensible precautions, undergirded by advances in medical research and the universal availability of good medical care. Many older persons and physicians treating older persons have adopted the concept which Callahan calls the "sundering" of illness and old age, that to be old is no longer to be considered synonymous with being ill. The somewhat irrational extension of these concepts, however, is the belief that the biologically determined decline of cellular and organ function can be overcome. Again to quote Callahan, "Medicine becomes not just a way of curing or controlling diseases, but no less a way of trying to cure or control the problems of life. We now expect to live long and healthy lives."

Callahan points out that these changing expectations, in combination with a skew in the ratio of the old to the young, have resulted in an increasingly large share of the expenditures for health care going to the elderly, with an increasing economic burden on all segments of society, including the family. He dramatically labels this phenomenon as a "social avalanche." His case becomes even more compelling when we are reminded that while modern medicine has controlled many of the killing diseases, it has unleashed the disabling diseases with their mounting economic, sociologic, and emotional burden on society.

It is on these observations that Callahan bases his contention that it is no longer tenable simply to try to use medicine to "vanquish or keep at bay the decline and death that have been the ineradicable marks of human aging." His stated objective for his book is "a call for limits, for sobriety of purpose, and for a willingness to ask once again how we might creatively and honorably accept aging and death when we become old, not always struggle to overcome them."

In his proposals for setting limits, the author thoughtfully and provocatively examines the full spectrum of society's relationship to aging. He explores the nature of the moral obligations of children to their aging parents and the limits that must be set between "imperative duties and

impossible demands" as well as the boundaries "to the demands of altruism and self-sacrifice on behalf of the elderly." This is balanced by a discussion of the needs of the elderly and their claim on the young. One need of the old is to have their vulnerability and dependence recognized and responded to. Often these needs can only be effectively responded to by the young, particularly in what Callahan calls the "affectional sphere." The old also need to have their veteranship acknowledged and be given the opportunity in their later years to make the kinds of contributions to the family that only the seasoned can bring about. Both the young and the old need to recognize and maintain the reciprocity that exists between them.

"In introducing his proposals for using age as a criterion in making treatment decisions, Callahan presents three principles as the basis for his argument."

Note: In addition to being central to the main thesis of the book, these sections are must reading for physicians dealing with aging patients and their children.

The role that the government and the community are best able to fulfill is to alleviate the financial burdens of the families. In this regard there is a cogent, humorous statement attributed to Ben Wattenberg.[4] "We (the older folks) don't like to take money from our kids. We don't want to be a burden. They don't like to give us money either. We all get angry with each other if we do it that way. So we sign a political contract to deal with what the anthropologists call 'the intergenerational transfer of wealth.' The young *give* money to the government. I *get* money from the government. That way we can both get mad at the government and keep on loving each other."

As an approach to the allocation of health resources to the elderly, Callahan presents six propositions. The first, one which should be discussed in some detail, is the recommendation that a suitable goal for medicine is for the old to achieve a natural life span, and beyond that to be concerned only with the relief of suffering. This statement obviously requires the definition of what Callahan considers a *natural life span.* His definition is related to what he calls a *tolerable death,* which is defined as "death at that stage in a life span when (a) one's life possibilities have on the whole been accomplished; (b) one's moral obligations to those for whom one has responsibilities have been discharged; (c) one's death will not seem to others as an offense to the sense or sensibilities, or tempt others to despair and rage at the finitude of human existence. This is not a biologic but is a biographic definition. *A natural life span may then be defined as one in which life's possibilities have on the whole been achieved and after which death may be understood as a sad, but nonetheless relatively acceptable event."*

This definition in turn contains many concepts which in and of themselves beg defining. Nonetheless, it deserves serious consideration as a basis for making the difficult decisions that older patients, their physicians, their families, and society are called on to make.

The other premises are: an appropriate understanding of the meaning and of the ends of aging including a personal meaning and a sense of service to the young and to the coming generations; a commitment by the young compatible with other social and familial obligations which will allow the elderly to reach the final phase of their life in dignity and security; the attainment of a death which is humane; to the extent possible, minimizing the economic and social anxieties which are so often a part of growing old.

Callahan also proposes that there be a "redeployment of economic and other resources to the good of society and its different age groups, not simply to the health and welfare of elderly individuals." This point and the one previously discussed, namely Callahan's concern with medicine's long-standing ambition to forestall death rather than turning its attention to the relief of suffering and the improvement in the physical and mental quality of life of the elderly, in my opinion does not acknowledge current trends in geriatric healthcare, research, and teaching. *I would also suggest that this proposition be redirected to advocate a general reexamination of the allocation of health resources, only one aspect of which relates to the elderly.*

In the logical progression of his argument, Callahan discusses age as a criterion for setting limits. He acknowledges that there may be some justification to use age as a criterion for the denial of some forms of government-subsidized medical care, but it is much more difficult to apply at the bedside.

Here he draws the distinction between age as a medical standard and age as person-centered or biographic standard. In exploring age as a medical standard, he turns to the report of the Office of Technologic Assessment on aging and life-extending technology.[5] Though age is associated with physical decline and comorbidity, age alone is not a valid predictor of medical outcome. Similarly, he concludes that although age-associated traits are a factor in determining the functioning of an older person, chronologic age alone as a biographic standard does not define the person.

He then raises the question, "Might the combination of age and other characteristics then be allowed to have a bearing on medical treatment, and particularly termination, decisions? The still more difficult dilemma is the morality of using age in any form as a criterion. This is particularly difficult in a society that adheres to the ethical principle that a patient's needs are the only valid criteria for determining treatment. Callahan develops the argument that "medical need is too indeterminate and elastic a concept to be used by itself," concluding that "some use of age will be *necessary* to make a judgment about terminating care of the elderly."

In introducing his proposals for using age as a criterion in making treatment decisions, Callahan presents three principles as the basis for his argument:

(1) "After a person has lived out a natural life span, medical care should no longer be oriented to resisting death."

(2) "Provision of medical care for those who have lived out a natural life span will be limited to the relief of suffering."

(3) "The existence of medical technologies capable of extending the lives of the elderly who have lived a natural life span creates no presumption whatever that the technologies must be used for that purpose." He does not assign a specific chronologic age to determine when a natural life span has been attained although he does hypothesize that it would normally be expected in the late 70s or early 80s.

"Contrary to what one might expect from the title of this book, Callahan's ideas and opinions . . . are neither radical nor are they antithetical to . . . the current concepts and trends in geriatric medicine."

It has been my experience that a growing number of older persons and their families have little difficulty accepting these principles. Many patients are relieved to have the opportunity to express their feelings and their wishes in making these decisions. Giving the patient the opportunity for self-determination by introducing the concept of the living will or the durable power of attorney can be as important if not more important than ordering a diagnostic procedure that is not likely to influence the management of a patient's illness.

Callahan proposes a guide (modified by this author) using three quality-of-life criteria that are useful in making the decision of appropriate levels of care.[6]

1. Physical and Mental Status
   (a) Patients with brain death
   (b) Patients in persistent vegetative state
   (c) Patients who are severely demented
   (d) Patients with mild to moderate impairment of competence
   (e) Severely ill, mentally alert patients
   (f) Physically frail, but not severely ill, mentally alert patients
   (g) Physically vigorous, mentally alert patients.
2. Quality of Life
   (a) Criteria of quality of life: capacity to think, feel, interact with others
   (b) Impediments to quality of life: severe pain and suffering or the effects of medication to relieve them, and any other condition that thwarts the capacity to think, feel, and interact with others.
3. Levels of Care
   (a) Emergency lifesaving intervention (e.g., CPR)
   (b) Intensive care and advance life support (ICU, mechanical ventilation)
   (c) General medical care (e.g., antibiotics, surgery, cancer chemotherapy, artificial hydration, and nutrition)
   (d) General nursing care for comfort and palliation
   (e) No nursing care.

As an example, a patient who is brain dead would receive no nursing care or that care which would preserve the patient's dignity and the family's sensitivities. At the other extreme, the patient who is physically vigorous and mentally alert with the capacity to think, feel and

interact with others would be considered for CPR and/or intensive care and advanced life support, absent a directive from the patient or the family to the contrary.

Experienced physicians will recognize this strategy as one which is used extensively and is applicable to patients of all ages. Although age is not included in Callahan's schema, he raises the following questions: "Is it not unfair to have standards of care, and particularly termination standards that are different for the old than for the young? If it would be reasonable to terminate medical treatment for an elderly person because of a bleak future, should that not be done with the young as well — for instance, in the case of a severely handicapped newborn? We are not forced to draw such conclusions. The elderly have already lived out a full life. They have not been denied (at least because of their age) the opportunities of living a life; and their death deprives them of less than it does a child or a young person who has had no such opportunity. Not only does it seem justifiable to work harder, and to take more chances, to save the life of a sick child, but also to allocate more resources to those conditions which cause premature death than to those which cause death after a long life. This is not, however, to say that the young should be oppressed by medical treatment in order that they might be saved, or that all technological means for extending the life of handicapped or critically ill children should be used . . . *I am only saying that it is proper to have different standards for young and old.*"

The author concludes with a thoughtful and provocative discussion of the most difficult question of all, namely the literal and symbolic aspects of limiting specific treatments such as hydration, nutrition, and antibiotics.

Contrary to what one might expect from the title of this book and from some of the questions raised in the introductory chapters, I did not find Daniel Callahan's ideas and opinions to be anathema. They are neither radical nor are they antithetical to what I would consider the current concepts and trends in geriatric medicine. They deserve serious examination by professionals and laymen alike.

Incidentally, Callahan wrote this book when he was between the ages of 56 and 57, aware of the statistical likelihood that he would live to be 80. He did so with the full realization that by the time he would be among the old, his own expectations as well as those who would be taking care of him will have changed. He states, "I have . . . presented my ideas because some significant change in our thinking about health care for the elderly is needed. . . . Our present course neither will nor should work. This book is an attempt to devise an alternative approach. I hope I would have the nerve to live with it."

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The Ethical Practice of Medicine

Robert N. Berg

ETHICS IN MEDICINE is hardly a new concept. As early as 2000 B.C., the Babylonians created the Code of Hammurabi, providing quite specific rules governing the nature and scope of physician practice. Subsequently, the Oath of Hippocrates, conceived somewhere around the 5th Century, B.C., provided a more general statement of principles, and served as the foundation for today's system of ethical rules and guidelines for physicians. It should also be noted that at the first official meeting of the American Medical Association in 1847, one of the two primary items of business on the agenda was the establishment of a Code of Ethics.[1]

In many states, including Georgia, the ethical practice of medicine has been elevated to a level going beyond the establishment of goals or ideals which physicians ought to strive to accomplish. Instead, it is the law: The Composite State Board of Medical Examiners is authorized to discipline a physician who has "engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person."[2] Thus, a physician who fails to comply with his or her ethical obligations runs the risk of license revocation or suspension. From this, it is of obvious importance for physicians to have a working knowledge of the ethical obligations imposed upon them.

"The physician has an affirmative ethical obligation to disclose to the patient or referring colleague his or her ownership interest in a (medical/health care) facility, prior to utilization."

In our experience, a large number of physicians tend to view their ethical obligations in the abstract. They are generally aware that the American Medical Association (AMA), through its Council on Ethical and Judicial Affairs, issues opinions which establish the ethical norms for physicians. They are also usually aware of the fact that MAG has adopted the AMA Current Opinions as its ethical standards as well. On closer examination, however, these physicians typically believe that the AMA's Current Opinions relate to public or social policy issues, rather than issues which may have a more pronounced bearing on a physician's day-to-day practice.

These physicians are partially correct, as the AMA does have a number of opinions on social policy issues. For example, the AMA provides ethical pronouncements on issues such as artificial insemination, capital punishment, fetal research, genetic engineering, organ transplants, surrogate mothers, and withholding or withdrawing life-prolonging medical treatment.[3] These issues typically are hotly debated and receive a lot of publicity.

At the same time, the AMA provides a number of ethical statements which may have daily application for the practicing physician. For example, we are often asked whether a physician is entitled to refuse to provide a patient, or a physician who may be about to treat that patient, with a copy of the patient's medical records, on the grounds that the patient's account was not current. In Georgia, there is a law which mandates that a physician provide a copy of the patient's medical record, upon request. This law does not permit the physician to refuse to do so on the grounds that the patient has not paid his or her bills.[4] Even without such a law in place, the answer would

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be the same, however, as the AMA Current Opinions clearly provide that "on request of the patient a physician should provide a copy or a summary of the [patient] record to the patient or to another physician, an attorney, or other person designated by the patient. . . . Medical reports should not be withheld because of an unpaid bill for medical services."[5]

'The AMA Current Opinions are not etched in stone. . . . As the practice of medicine evolves, the Current Opinions also evolve, with new ethical pronouncements added on specific practice issues and with outdated ethical opinions deleted.'

Physicians oftentimes are also surprised to learn that it is not unethical for a physician to charge a patient for a missed appointment or for one not canceled at least 24 hours in advance. The AMA suggests that this practice by used "infrequently and always with the utmost consideration for the patient and his circumstances." It is also important for the physician to ensure that the patient is fully advised that such a charge will be made.[6] As a general matter, however, it is not unethical to impose cancellation charges in appropriate circumstances.

In the last 10 years, physicians have become more involved in joint ventures, which typically result in physicians obtaining ownership interests in health care facilities. Since physicians oftentimes will refer their patients to these facilities, ethical issues may arise, and the AMA has provided a number of pronouncements which relate, in some manner, to the conflicts of interest involved in the physician ownership of health care facilities.

Some of the AMA's ethical statements regarding physician joint ventures are self-evident: The physician must comply with the law; the patient should have free choice either to use the physician's propriety facility or to seek the needed medical services elsewhere; and, the physician should not put himself or herself in a conflict situation, where the physician's commercial interest is incompatible with the interests of the patient.[7] In essence, the physician must put the patient's interests above his or her own financial interests.

Physicians are often surprised to learn, however, that where the physician refers a patient to a facility in which that physician has an ownership interest, the physician also has *an affirmative ethical obligation* to disclose to the patient or referring colleague his or her ownership interest in the facility, prior to utilization.[8] The exact form of disclosure is not specified by the AMA. Under certain circumstances, it may be appropriate to use a written disclosure form; in other cases, a posted notice may be sufficient. Similarly, the content of the notice is not regulated by the AMA. It may be appropriate simply to refer to the fact that the physician has "an ownership interest" in a health care facility; alternatively, in a particular case, it may be proper to go further and indicate the type of ownership interest involved (e.g., that the physician is a limited partner in a limited partnership which owns the facility, or that the physician is the sole owner of a facility).

The AMA Current Opinions are not like the Ten Commandments; they are neither etched in stone nor couched in broad, sweeping terms. Quite the contrary, as the practice of medicine evolves, the AMA Current Opinions also evolve, with new ethical pronouncements added on specific practice issues and with outdated ethical opinions deleted. In light of the importance of complying with the physician's ethical obligations — not only in terms of satisfying each physician's commitment to uphold the Hippocratic Oath, but also in terms of complying with the law — it would be wise for all physicians to become more aware of the specific issues covered in the AMA Current Opinions. A copy of the AMA Current Opinions costs $8 for AMA members and may be ordered at the following address: Order Dept. OP-122/9, American Medical Association, P.O. Box 10946, Chicago, IL 60610-0946; PH: 312-645-5000.

Notes

1. Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, 1989 Edition ("AMA Current Opinions"), at p. vii.
2. O.C.G.A. §43-34-37(a)(7).
3. See AMA Current Opinions, Chapter 2.00.
4. O.C.G.A. §31-33-1et seq.
5. AMA Current Opinions, at Section 7.02.
6. AMA Current Opinions, at Section 8.01.
7. AMA Current Opinions, at Section 8.03.
8. *Id.*

Angioplasty in Complex Multivessel Disease: Will it Replace Surgery?

Spencer B. King III, M.D.

CORONARY ANGIOPLASTY was first applied by Gruentzig in 1977 in a patient with a proximal discrete lesion in the anterior descending coronary artery.[1] This type lesion characterized the early indications for angioplasty, and it was felt for several years that more complex disease would remain the purview of surgery. Over the past 13 years, angioplasty has expanded so that patients formerly undergoing surgery and formerly undergoing medical therapy are now having angioplasty in increasing numbers. A recent review of the experience at Emory University Hospital[2] shows that in 1981 only 10% of patients undergoing revascularization procedures were having coronary angioplasty, while approximately 40% underwent surgery and 50% medical therapy. Eight years later, roughly 1/3 of patients were initially treated with surgery, 1/3 with angioplasty, and 1/3 with medical therapy. In fact, in 1989, a year in which 1700 PTCA procedures were performed at Emory, angioplasty replaced surgery as the predominant initial therapy for patients with coronary artery disease.

In a report on indications for angioplasty by a joint committee of the American College of Cardiology and the American Heart Association, guidelines for the performance of the procedure were proposed.[3] These guidelines categories: those felt to be generally accepted throughout the medical community, those about which there is a variance of opinion, and those generally agreed to be contraindications for the technique. In that report, the generally agreed upon indications were relatively narrow and were limited to those patients with ischemia and single vessel disease or those with less complex forms of multivessel disease. More complex forms of multivessel disease fell into the controversial category where opinions vary widely throughout the country.

"The hypothesis to be tested in the EAST trial is whether patients undergoing angioplasty would have a comparable outcome to patients undergoing bypass surgery."

Emory Angioplasty Surgery Trial (EAST)

In an effort to further define the indications for angioplasty in complex multivessel disease, a randomized trial was proposed at Emory and later funded by the National Institutes of Health. This trial, called EAST (Emory Angioplasty Surgery Trial) began enrolling patients in July of 1987 and the enrollment phase was completed in April of 1990. The hypothesis to be tested is whether such patients undergoing angioplasty would have a comparable outcome to patients undergoing bypass surgery. Patients included in the trial are those with significant involvement of two or three of the major epicardial coronary artery systems, a constellation of symptoms and/or documented ischemia which is felt to warrant revascularization in the opinion of the attending physicians and in whom surgical revascularization would indeed be a reasonable strategy. Patients are excluded on clinical grounds if there has been prior angioplasty, prior surgery, a myocardial infarction within 5 days of randomization, other associated life-threatening illnesses, a need for noncoronary cardiac surgery such as valve replacement, and such mundane matters as the point of origin of the patient which might make careful follow-up difficult. Additional angiographic exclusions include left main coronary artery disease, total occlusion of two or more epicardial coronaries suitable for

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bypass grafting, total occlusion of one coronary artery if that occlusion is greater than 8 weeks old and serves a viable segment of the myocardium which would benefit from bypass grafting, and some particularly long and tortuous coronary lesions which would preclude successful angioplasty.

Over 4,000 patients with multivessel disease without prior surgery or angioplasty were screened and of that number, approximately 800 met the criteria and were eligible for the trial. Half of the patients eligible were subsequently enrolled in the randomized portion of the trial. The remainder of the patients are being followed in a registry which will track their progress as well.

The primary endpoint of the trial will measure the outcome of the patients at 1 and 3 years using a composite endpoint of freedom from: death, myocardial infarction, or a large ischemic burden documented on SPECT thallium tomography. All patients will undergo thallium exercise testing and quantiative coronary arteriography at 1 and 3 years following randomization and subsequent therapy with PTCA or CABG. The quantitative angiograms are being evaluated by the angiography lab located at the University of Washington, and these results will be correlated with clinical events as well as the exercise thallium scans. Very important questions will include the relationship of the degree of revascularization documented angiographically to the freedom from occurrence of the primary endpoint which is a vital/functional one. Another important question will be the degree to which additional procedures are required in each group to achieve the endpoint that occurs at 1 year and 3 years. In other words, particularly in the patients undergoing coronary angioplasty, how often is bypass surgery required in the follow-up period? Should the results of this trial be comparable, then the economic costs of these strategies will be of great interest. Careful economic analysis in collaboration with the Department of Economics at Emory are being carried out. These will involve analysis of all hospital and professional charges accumulated at Emory and Crawford Long Hospitals plus a modelling type analysis on the procedures and repeat hospitalizations required elsewhere.

"The BARI investigation will have similar entry criteria as EAST and will attempt to enroll adequate numbers of patients to utilize the mortality figures as endpoints."

Bypass Angioplasty Revascularization Investigation (BARI)

A similar trial also sponsored by the National Heart Lung and Blood Institute is being conducted in 15 centers. This investigation called BARI (Bypass Angioplasty Revascularization Investigation) will have similar entry criteria as EAST and will attempt to enroll adequate numbers of patients to utilize the mortality figures as endpoints. The trial will have a longer follow-up than EAST but will not have systemic angiography and SPECT thallium testing applied to all patients. The results of these trials will go a long way towards improving our understanding of the indications for angioplasty in multivessel disease. We can look forward to the results of the EAST trial in 1993 following completion of the three year follow-up. BARI results will not be available for several more years.[4]

Whereas such trials will go a long way towards improving our ability to make decisions, a great many patients with complex multivessel disease are not being studied in such trials. As a matter of fact, more patients were excluded from these trials than were included. These include patients with multiple total occlusions, left main stenosis, very poor left ventricular function, as well as patients who would not be deemed severe enough to warrant bypass surgery. Decisions on surgery or angioplasty on these patients will have to rely on clinical judgment in the absence of any future randomized trials. A review of the patients undergoing angioplasty with multivessel disease at Emory prior to the beginning of this trial has been carried out.[5] Twelve hundred patients with multivessel disease underwent angioplasty between 1980 and mid 1987, and 97% remained free from cardiac death at 3 years and 95% at 5 years. For those discharged from the initial hospitalization, 83% remained free from bypass surgery at 5 years. It must be remembered, however, that these encouraging results were obtained in an era when bypass surgery was performed on many of the more complex multivessel cases. The complexity of multivessel cases we are asked to see has certainly increased since 1987.

An increasing population of patients undergoing angioplasty are those at uniquely

high risk for bypass surgery. In these cases, although angioplasty carries a significant risk, that is felt to be less than the risk which would be encountered by undergoing bypass surgery. Many cases of this sort are referred from cardiac surgeons and quite frequently have had prior bypass surgery. The approach to selection in patients with prior bypass surgery differs from that used in patients without a prior procedure. A number of studies have shown that repeat bypass surgery carries a higher risk than de novo surgery, and this increases with each time the chest is opened. The attitude in selecting de novo patients should be to weigh the risk and benefits not only of the initial procedure, but the long-term outcome. In patients with prior bypass surgery, the approach is frequently to consider angioplasty if it is reasonable to rely on bypass surgery when angioplasty cannot improve the situation. Patients with prior bypass surgery who are ideal candidates for angioplasty include those who have involvement of the native coronary arteries or the anastamosis of vein grafts or internal mammary grafts with the native coronary artery. Those patients who have chronic diffuse disease in vein grafts have a higher rate of restenosis but frequently one or multiple angioplasties in a vein graft is preferable to a repeat operation, depending on the risk the individual patient is under. Vein grafts which become diseased within 1 to 3 years after implantation carry a significantly better chance with angioplasty than vein grafts which have been implanted many years prior.

New technology may improve the ability to handle complex multivessel disease patients. We have been applying excimer laser therapy to some long diffusely diseased vessels with the hope that the initial complication rates will be reduced by this technique. Coronary atherectomy has been helpful in particularly eccentric lesions which do not respond well to PTCA, and intracoronary stents have been critical in some high risk patients as either a bridge to bypass surgery or as a permanent scaffolding to hold the artery open in those patients in whom surgery is either then unnecessary or too risky. An important hope and expectation for the future is that the restenosis process can be further improved and in particular that methods for controlling the renarrowing of vein grafts can be achieved. One promising approach is the use of a stent within vein grafts to hold the large amount of atheromatous material away from the lumen.

‘An important hope and expectation for the future is that the restenosis process can be further improved and in particular that methods for controlling the renarrowing of vein grafts can be achieved.’

The aggressiveness of cardiologists in approaching complex multivessel disease has obviously increased but should be kept under close surveillance and measured against the gold standard of bypass surgery. An ideal arrangement is for close collaboration between the angioplasty operators and surgeons on the difficult cases so that the relative risk and the chance for successful procedures can be well thought out. Whereas angioplasty of straightforward discrete stenoses has been the purview of a large number of cardiologists, the long diffuse, tortuous, bifurcated and eccentric lesions, especially in patients with multivessel disease, are best handled by highly experienced operators. Even with the availability of multiple investigative devices such as lasers, atherectomy, and stents, many complex multivessel cases are still best handled by surgery. A large experience in both procedures is important in making careful judgments as to whether surgery or angioplasty should be performed.

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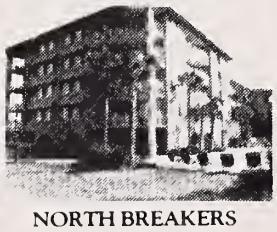

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> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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DECEMBER 1990

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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"The great thing in this world is not so much where we stand, as it is in what direction we are moving. To reach the port of heaven, we must sail, sometimes with the wind, sometimes against it — but we must sail, not drift, nor lie at anchor."

—Oliver Wendell Holmes

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THE COVER

This portion of Joseph Perrin's *Chroma 4000* conveys much of the emotion inherent in this holiday season. Mr. Perrin is Head and Professor Emeritus, School of Art and Design, Georgia State University. Read more about him on p. 885.

Special thanks to Mr. Phil Shone, Atlanta photographer, who supplied us with a transparency of Mr. Perrin's art.

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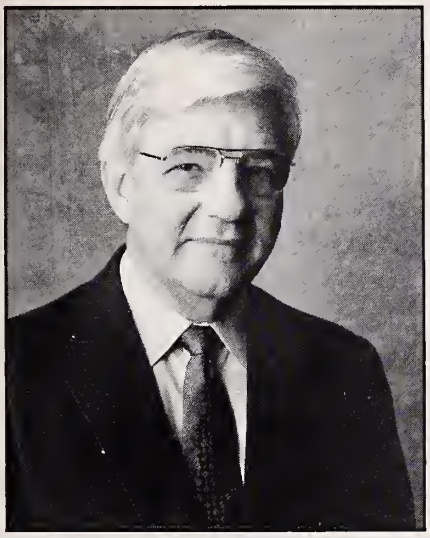

William C. Collins, M.D.

"Good Wine Needs No Bush"

WINE AND SO-CALLED "Western civilization" go so hand in hand that a map of the world's vineyards and a map of "Western man" are almost the same. Many of our colleagues in Georgia medicine have pursued cultivated tastes in wines that reflect well on our state as a cultural pearl in the Southern landscape. In recent years, a few brave souls have dared to actually produce wine in our state, most notably Habersham Vineyards and Chateau Elan, and they seem destined to change the public's perception of Georgia's fermentation expertise as being limited to "white lightening" or "moonshine." I compliment both our nouveau vintners and our old-time connoisseurs such as Dick King, Milton Bryant, Charlie Hatcher, and Newt Clark. I will not attempt to discuss the color, scent, or taste of their cherished Bordeaux, Burgundy, or Rhine wines, but urge you to purchase for yourself Hugh Johnson's, *The World Atlas of Wine* and join with them in this wonderful pastime.

Rather, it is my purpose to lift before you today not a sparkling champagne, but what I will refer to as the "wisdom of wine" and how we can apply some ancient and not-so-ancient Western aphorisms of the grape to the modern state of medicine.

"We will serve no wine before its time." No one will ever forget the melodious sounds of Orson Welles, espousing the virtues of a modern California vintage. The wisdom hidden in this statement, to me, seems to beg the modern medical media to allow "modern medical miracles" to be evaluated by the hard eye of scientific evaluation in peer review before taking the latest article from the *JAMA* or *The New England Journal of Medicine* and touting it as the know-all and end-all in medical care. The practice of sensationalism in medical advances must be brought under control.

In Chaucer's prologue to the Manciples Tale, the Manciple (or purveyor) says, "I trust ye have drunken wine of ape," i.e., wine to make you foolishly drunk. According to Rabbinical traditions, Satan came to Noah when he was planting vines and slew a lamb, a lion, a pig, and an ape, to teach Noah that man, in turn, reveals the characteristics of all four according to the amount of wine consumed. This certainly can be a lesson to all physicians to champion the practice of moderation in all things, be it wine or fees, food or patient care.

In Matthew 9:17, we are taught, "Neither do men put new wine into old bottles, else the bottles break and the wine runneth out and the bottles perish." Modern translation of this Biblical teaching says do not impose new practices, ideas, etc. on people or things too old or too unfit to stand the stress. Here is the meat of my diatribe! The new wine of medical and professional advertising allowed and promoted by the Federal Trade Commission, as it seeks to tear apart the very bone and sinew of our professional organizations, is tearing this "old wine bottle" apart. I get as sick as if I had "tarried too long in the taverns" when I see billboards and television ads promoting medical care as if it were a beer or cola concoction.

"Good wines need no bush." The familiar quote from Shakespeare's "As You Like It," sums up my wine wisdom message. In ancient times an ivy bush, thought to be sacred to Bacchus, the Roman god of wine, was once the sign of taverns or ale vendors to announce a harvest of "new wine." So just as a good wine or a purveyor of good reputation needed no advertisement, neither does good medical care. The caring, competent medical practitioner does not need to announce his competence or merit by beating a cymbal on the highest hill or peddling his snake oil from the gaudiest wagon at the fair. One's reputation and standing in the medical community should not be influenced by whoever has the largest PR budget, but in the old fashioned way — one should *earn* it.

The State of Israel recently outlawed all professional advertising, and one can only hope that the wisdom of this ancient culture will blow rapidly across the waters to our shores. I congratulate our Israeli professional colleagues who certainly have said, in no uncertain terms, "Good wine needs no bush!"

NEW MEMBERS

Ah, Robert W., Internal Medicine — Stephens-Rabun — (Active N2) 800 East Doyle Street, Toccoa 30577

Belvin, Robert E., Internal Medicine — Floyd-Polk-Chattooga — (Active N2) 141 Guest House Court, #187 Rome 30161

Brandt, David J., Diagnostic Radiology — MAA — (Active) 1984 Peachtree Rd., N.W., Suite 505, Atlanta 30309

Chen, Bessie B., Anesthesiology — MAA — (Active N2) 1580 Bakers Glen Drive, Atlanta 30350

Guilder, Stephen E., Otolaryngology — MAA — (Resident) 4553 North Shallowford Road, Atlanta 30338

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Kleber, Scott B., Internal Medicine — MAA — (Active N2) 478 Peachtree Street, N.E., Suite 107-A, Atlanta 30308

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Thompson, Grady A., Family Practice — Dougherty — (Active) 420 Fourth Avenue, Albany 31701

Tuck, Robert S., Internal Medicine — Whitfield-Murray — (Active N2) Hospital Drive, Chatsworth 30705

Tygrett, Patricia J., Family Practice — Gordon — (Active) 325 South Wall Street, Calhoun 30701

PERSONALS

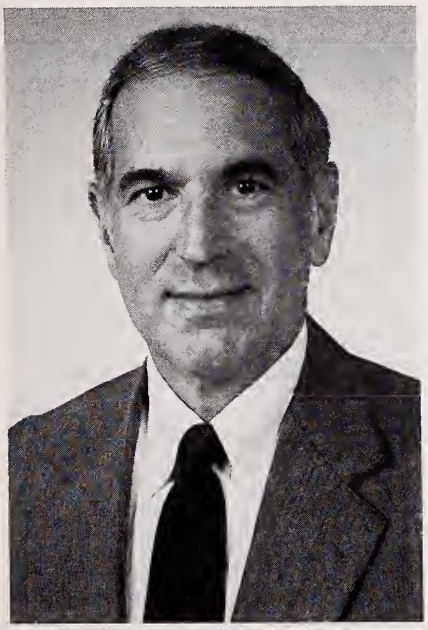
Cobb CMS
Marietta general surgeon and *Journal* editor **Charles R. Underwood, M.D.,** received the Stephen D. Vaughn Award at the annual meeting of the Georgia Division of the American Cancer Society (ACS) last October. The award recognized him as the most outstanding volunteer in the Georgia Division of the ACS. It is given in memory of Stephen D. Vaughn, the ACS's Executive Vice President who died of cancer in 1984 at the age of 37. Dr. Underwood was honored for his "attitudes of service and contributions to the ACS as evidenced by his dedication, commitment, and active participation in the Society's work."

Georgia Medical Society
Lloyd B. Schnuck, Jr., M.D., from Savannah, was named a Fellow of the American College of Radiology for his outstanding contributions to the field of radiology.

Medical Association of Atlanta
Atlanta ophthalmologist **Thomas S. Harbin Jr., M.D.,** has been named to the Piedmont Medical Center board of directors for a 5-year term. Dr. Harbin joined the

Charles R. Underwood, M.D., (L), Marietta surgeon, is presented with the Stephen D. Vaughn Award by Dick Ivey, Chairman of the Georgia Division, American Cancer Society, Awards Committee. Dr. Underwood was honored as the most outstanding volunteer of the year.

Piedmont Hospital medical staff in 1976 and was appointed chief of ophthalmology in 1984. In 1985, he received the American Academy of Ophthalmology's Honor Award. He is currently clinical professor of ophthalmology at Emory University School of Medicine.



William E. Silver, M.D., Southern Regional Vice President of the American Academy of Facial and Plastic and Reconstructive Surgery.

William E. Silver, M.D., an Atlanta facial plastic surgeon and Fellow of the American Academy of Facial Plastic and Reconstructive Surgery, was recently elected to the position of Southern Regional Vice President during the Academy's 1990 fall meeting held in San Diego, California. Dr. Silver just finished his term of office as the Vice President of the American Academy of Otolaryngology-Head and Neck Surgery where he has been a board member for 3 years.

Spalding CMS
Griffin pediatrician **Ann D. Stuckey, M.D.,** retired last October after 46 years in practice. Dr. Stuckey served patients in Forsyth and Monroe counties.

Whitfield-Murray CMS
Dalton family practitioner **David A. Wells, M.D.,** was honored by Whitfield County commissioners for "his outstanding contribution to this community through his leadership." Dr. Wells has served on the county health board since the early 1960s and has been its chairman since 1973. He is retiring from his 36-year private practice to head up the Medical College of Georgia's rural health department in Augusta.

DEATHS

Hartwell Joiner, M.D., an internist from Gainesville, died last October at the age of 87. He had retired in 1985 after 55 years of practicing medicine.

Dr. Joiner was a charter member and past director of Georgia Heart Association, former director of the Georgia Cancer Society, on the Hall County Health Board and a director of Citizens Bank. He was also former president of Hall County Medical Society and former secretary of the Ninth District Medical Society.

Gainesville Rotary Club was one of Dr. Joiner's major interests. He was a past president and was active in numerous club projects and programs. He had been a trustee of Georgia Rotary Student Fund. Dr. Joiner also contributed to the community through his leadership on the Hall County Hospital Authority.

During World War II, he served with Emory Unit, Third General Hospital, in Europe and North Africa, attaining the rank of lieutenant colonel. Dr. Joiner was one of the physicians treating the many injured in the 1936 tornado that killed more than 200 in Gainesville. At the time, he was the physician at Riverside Military Academy.

James F. Schwartz, M.D. of Atlanta, professor of pediatrics and neurology at the Emory University School of Medicine, died of cancer last October. He was 60.

Dr. Schwartz had taught at the Emory University School of Medicine since 1963. He was named professor of pediatrics in 1970 and became professor of neurology in 1975. He was also associate medical director of the Egleston Hospital for Children.

Dr. Schwartz graduated from Swarthmore College and the University of Rochester School of Medicine and Dentistry. He completed his residency in pediatrics at the Yale-New Haven Hospital and his training in neurology at Columbia Presbyterian Hospital.

Dr. Schwartz was a member of the American Pediatric Society and the American Neurological Association. He was a member of the executive board of Child Neurology Society from 1972 to 1976 and was the society president from 1975 to 1976. He was a member of the advisory board for Physicians for Social Responsibility-Atlanta.

QUOTES

Each loves itself, but not itself alone,
Each sex desires alike, till two are one,
Nor ends the pleasure with the fierce embrace;
They love themselves a third time in their race.

ALEXANDER POPE:
An Essay on Man, III, 1733

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physicians Recognition Award (PRA) from April through September, 1990.*

The award was established by the AMA House of Delegates in 1968 "To recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review, at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category I credit by organizations accredited for these activities.

We can congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Gloria E. Joco Abad, *Dublin*
Maximo C. Abellana, *Montezuma*
John Stephen Antalis, *Dalton*
Ivan Arnold Backerman, *East Point*
Thomas Waite Bantly, *Tucker*
Daniel Louis Barrow, *Atlanta*
John Baynard Baxley, *Augusta*
William Roseboro Beach, *Atlanta*
Douglas Ronald Bess, *Atlanta*
Marvin Blase, *Atlanta*
David Lee Booker, *Augusta*
Larry Bregman, *Atlanta*
Ruth Cardwell Brown, *Atlanta*
Vickie Mixon Brown, *Milledgeville*
William Michael Brown, *Marietta*
Rodney Mack Browne, *Macon*
James R. Burns, *Gainesville*
John Knox Burns, *Gainesville*
David Emerson Burtner, *Macon*
Dwana Marie Bush, *Atlanta*
James Andrew Campbell, *Fitzgerald*
William Joseph Casarella, *Atlanta*
Charles Irving Caulton, *Milledgeville*
George Milton Chastain, *Albany*
William T. Collins, *Tucker*
William H. Conner, *Atlanta*
Lauren Elise Cosgrove, *Atlanta*
Marc Scott D'Angelo, *Thomasville*
Frank Morris Davis, *Tifton*
Jayaprakash Desai, *Lawrenceville*
William Cross Dudney, *Columbus*
Keith Errett Ellis, *Savannah*
Goodman Basil Espy, *Marietta*
James Armour Evans, *Columbus*
Richard Shafter Field, *Augusta*
Jorge Valentin Figueredo, *Lithia Springs*
Donald Joseph Filip, *Atlanta*
Paul Gerald Firth, *Macon*
Joseph Bernard Floyd, *Stone Mountain*
David Jay Frolich, *Macon*
Virginia Garrett Galvin, *Atlanta*
Raymond L. Gilbert, Athens
Cary Bruce Gilman, *Lithonia*
Glenn Adam Gingold, *Blue Ridge*
John Abner Goldman, *Atlanta*
Adam Oliver Goldstein, *Augusta*
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ACP Responds to ASIM Article

Dear Editor,

The article by Albert Carr, MD, on "Access to Medical Care" in the October 19, 1990, issue contains wanton misrepresentations which merit correction. The first is the title, "Access to Medical Care: A Perspective of Internal Medicine." It should read, "Access to Medical Care: A Perspective of Albert A. Carr, MD, President of the Georgia Society of Internal Medicine," because it certainly does not represent the perspectives of the American College of Physicians and its more than thirteen hundred Georgia internists.

In the article, Dr. Carr moves from his perceptions of an internist, cost-effectiveness, cost benefits, Medicaid, and the Oregon plan to the American College of Physicians (ACP) and American Society of Internal Medicine's (ASIM) plans on access to health care.

He writes, "the ACP position . . . implies the need for a complete change from the present private/public payers system to a single-payor system." He also states, "The funding is to be generated by general tax revenues or a surcharge on income taxes or payroll taxes or income related premiums." How he came to those absolutely erroneous conclusions is not stated.

No where in the ACP access position paper (*Annals of Internal Medicine*, May 1, 1990) is support of a single payor system either mentioned or implied. Indeed, if Dr. Carr had "read in detail" the paper, as he advised others to do, he would have read, "for a new system to be financially viable it must, when possible, continue to capture those resources currently financing health care services." Our plan could very well include a substantial role for private insurance.

Let me briefly state the ACP Access position. We recognize that our present health care system has major flaws that require fundamental changes. While it works well for many of us, it does not work well for some 35-37 million Americans who have no insurance coverage and many others who are underinsured or having increasing difficulties obtaining or keeping insurance. It is too complex, too expensive, and too burdensome for our patients and their physicians. Malpractice insurance and the tort system are out of control. Utilization review is for rationing rather than quality. These flaws need sound, data-based and long-term reform. The ACP does not think that simply expanding state Medicaid and mandating small employers insurance coverage is the best answer to our enormous national problem.

The ACP does not yet have the answers, but we are actively working on them. We have developed criteria for evaluating and comparing plans and systems. The best plan should come, we believe, from the collective wisdom of our patients, consumer groups, small and large businesses, the insurance industry, and our fellow physicians. Working together we shall devise a plan that is uniquely American.

Unfortunately, Dr. Carr's article is a polemic in support of one internal medicine organization (ASIM) over another one (ACP). Perhaps he has not heard that in September, 1990, leaders of these two organizations met in Washington to discuss their differences. They agreed to stop internecine bickering and to work together in support of the beleaguered speciality of Internal Medicine. Sadly, Dr. Carr continues to do battle when the better and smarter action would be working constructively and cordially for our patients and our profession.

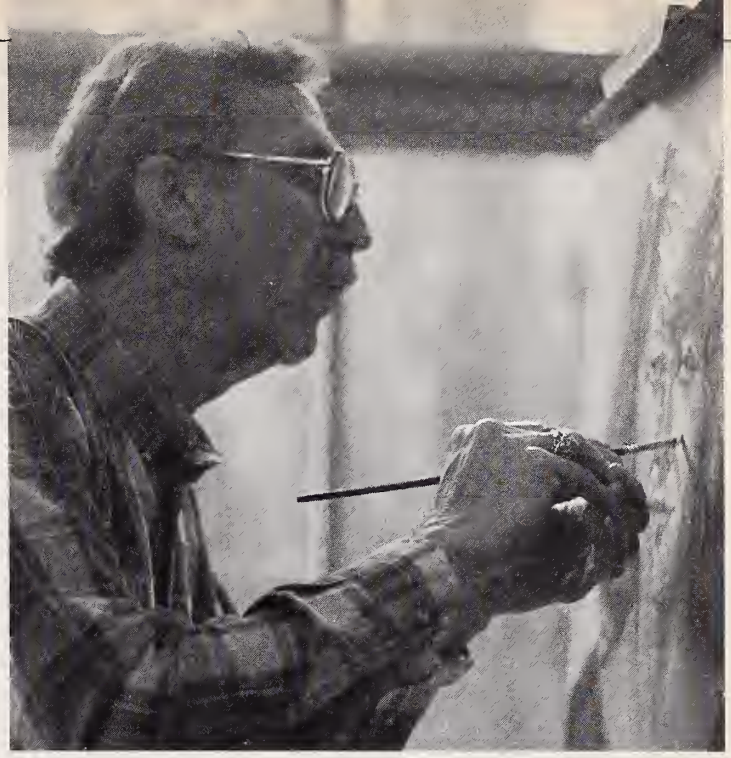
The most important lessons from the Medicare mess in Georgia may be how poorly we have made our patients aware of current threats to their care, and how ineffective medical organizations have been in responding to those threats.

Sincerely,

Robert B. Copeland, M.D., FACP
Governor for Georgia
American College of Physicians

About the Cover Artist:

Joseph Perrin



JOSEPH PERRIN is a native of DeKalb County, Georgia. Educated in DeKalb County Schools, at Georgia Tech and Virginia Tech, he holds art degrees from the University of Georgia and the University of California at Los Angeles, where he majored in painting. He is retired Chairman of the Department of Art at Georgia State University, where he served for 29 years. Mr. Perrin is a member of Phi Kappa Phi Honor Society and Omicron Delta Kappa leadership honorary fraternity. He has been the recipient of a Danforth Foundation Grant and has served as a Danforth featured lecturer. He has also been a recipient of the Governor's Arts Award, The Atlanta Civic Design Commission Award, and the Civitan Citizen of the Year Award from his home town, Clarkston.

Active in community affairs, Mr. Perrin is an honorary member of the Board of the Atlanta Arts Festival, past president of the Southeast College Art Association, a former member of the Board of Sponsors of the High Museum. He is Chairman of the M.A.R.T.A. Arts Council. He was a member of the Georgia Council for the Arts and Humanities for more than fifteen years. He serves on the Art Council of the Atlanta Public Library system.

Mr. Perrin has exhibited locally, nationally, and internationally. He has won the Painting of the Year Award, the Atlanta Arts Festival First Award and the Garden's Exhibition First Award, among others. One man shows include a major retrospective at the High Museum of Art in 1969. He has participated in the Embassies Around the World Art Program. He is represented in a number of museums including the High Museum and the Georgia Museum of Art as well as in many corporate and private collections listed below. Exhibitions include a one-man show at the Fay Gold Gallery, Peachtree Center Gallery, Creative Arts Guild, and the Metropolitan Museum in Brazil and retrospective exhibitions at Georgia State University and The Handshake Gallery in 1979. A 40-year retrospective of his work was held in Atlanta last month at the new Promenade Two. Sponsored by RE/Max of Georgia and WXIA Television, proceeds from a silent auction of a wide variety of Georgia artists went to the Atlanta Children's Shelter, My Turn Now, and the establishment of an art scholarship in honor of Mr. Perrin at Georgia State University.

He is author of a number of articles and essays published in a variety of magazines, including *Southern Homes*, *Art Business News*, *Atlanta Magazine*, and *The Atlanta Economic Review*.

Commissions include the interior wall design for the West Lake Avenue Station of the Metropolitan Atlanta Rapid Transit Authority; "Multivision," an eight-canvas painting for Dr. and Mrs. Bruce Green; "Romanesque," a six-canvas painting for Dr. and Mrs. Richard Steele; and "Station #2" for the Atlanta City Club. The art on this Journal was originally commissioned by Rich's and consists of four canvasses involving 4000 colors. He also co-designed the Ark of the Covenant in the Massell Chapel of the Temple, Atlanta, Georgia.

Collections:

High Museum of Art, Atlanta
Georgia Museum of Art, Athens
Metropolitan Museum of Art, Recife, Brazil
Carter Presidential Center, Atlanta
President of Mexico
Chattahoochee Valley Art Museum
University of Georgia, Athens, Georgia
Georgia State University, Atlanta
Mead Packaging, Inc., Dayton, Ohio
Bank South, Atlanta
Fuqua Industries, Atlanta
Arthur Andersen and Company, Atlanta
King and Spalding, Atlanta
Troutman/Sanders, Atlanta
Kilpatrick and Cody, Atlanta
Stratton Industries, Atlanta
Carter and Associates, Atlanta
Mr. and Mrs. Alvin Ferst, Atlanta
Mr. and Mrs. Lucius Tippet, Atlanta
Mr. and Mrs. Cecil Alexander, Atlanta
Mr. and Mrs. Mark Taylor, Atlanta
Mr. and Mrs. Wayne Vason, Atlanta
Mr. and Mrs. Louis Regenstein, Atlanta
Mr. Elliot Haas, Atlanta
Fidelity National Bank
Many others

CALENDAR

JANUARY 1991

14-15 — *Atlanta:* **Quantitative Thallium Myocardial Tomography**. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14-18 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28-1 Feb. — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

FEBRUARY 1991

2-9 — *Steamboat Springs, CO:* **New Horizons in Anesthesiology.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

8-9 — *Atlanta:* **Pediatric Orthopaedic Seminar.** Contact Darlene Baugus, Scottish Rite Children's Medical Center, 1001 Johnson Ferry Road, N.E., Atlanta 30363. PH: 404/250-2138.

11-12 — *Atlanta:* **TC-99M Myocardial Spect.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd. Atlanta 30322. PH 404/7275695.

11-15 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-16 — *Atlanta*: **Retina Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-23 — *Atlanta:* **28th Annual Ophthalmology Conference.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-1 Mar. — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

MARCH 1991

1-2 — *Augusta:* **Flexible Fiberoptic Sigmoidoscopy.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

2-9 — *Snowmass, CO:* **Sixteenth Annual Snow Job in Gynecology and Obstetrics.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-15 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-16 — *Augusta:* **26th Annual Family Practice Symposium.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

22 — *Macon:* **1991 Cherry Blossom Psychiatric Symposium.** Category 1 credit. Contact Robert Fore, Ed.D., Division of CME, 777 Hemlock St., Macon 31201. PH: 912/744-1061.

22-23 — *Augusta:* **Ophthalmology.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912-1400. PH: 404/721-3967.

25-26 — *Atlanta:* **Quantitative Thallium Myocardial Tomography.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-29 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

APRIL 1991

5-6 — *Atlanta:* **Pharmacology for the Anesthesiologist.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-10 — *Atlanta:* **Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXV.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-16 — *Atlanta:* **TC-99M Myocardial Spect.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-19 — *Atlanta:* **Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

17-19 — *Atlanta:* **Nutrition and Cancer.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

Of Joy and Thankfulness

"We are all of us compelled to read for profit, party for contacts, lunch for contracts, bowl for unity, drive for mileage, gamble for charity, go out for the evening for the greater glory of the municipality, and stay home for the weekend to rebuild the house. Minutes, hours, and days have been spared us. The prospect of filling them with the pleasures for which they were spared us has somehow come to seem meaningless, meaningless enough to drive some of us to drink and some of us to doctors and all of us to the satisfactions of an insatiate industry. In a contrary and perhaps rather cruel way the twentieth century has relieved us of labor without at the same time relieving us of the conviction that only labor is meaningful. . . .

It is probable that our very awareness of the existence of pleasures that we are either postponing or denying ourselves adds to the tensions induced by unrelieved labor. We feel guilty when we take our pleasure, because there is so much work we might do. We feel guilty when we work so hard, because our lives may depend upon pausing for pleasure. The two guilts are incompatible, and we suffer further from the head of steam their mutual abrasiveness builds up. Still, there is always hope of resolving the dilemma; the life line may be badly snarled, but it has not been permanently cut . . .

It is almost as though the Twentieth Century had been engaged in a long struggle to produce a new kind of man — a man whose sole concern should be his useful work — and, in our children, had successfully accomplished the mutation."

The Decline of Pleasure
WALTER KERR

"Meanwhile, where is God? This is one of the most disquieting symptoms. When you are happy, so happy that you have no sense of needing Him, so happy that you are tempted to feel His claims upon you as an interruption, if you remember yourself and turn to Him with gratitude and praise, you will be — or so it feels — welcomed with open arms. But go to Him when your need is desperate, when all other help is vain, and what do you find? A door slammed in your face, and a sound of bolting and double bolting on the inside. After that, silence. You may as well turn away. The longer you wait, the more emphatic the silence will become. There are no lights in the windows. It might be an empty house. Was it ever inhabited? It seemed so once. And that seeming was as strong as this. What can this mean? Why is He so present a commander in our time of prosperity and so very absent a help in time of trouble? . . .

Feelings, and feelings, and feelings. Let me try thinking instead. From the rational point of view, what new factor has H's death introduced into the problem of the universe? What grounds has it given me for doubting all that I believe? I knew already that these things, and worse, happened daily. I would have said that I had taken them into account. I had been warned — I had warned myself — not to reckon on worldly happiness. We were even promised sufferings. They were part of the programme. We were even told, 'Blessed are they that mourn,' and I accepted it. I've got nothing that I hadn't bargained for. Of course it is different when the thing happens to oneself, not to others, and in reality, not in imagination. Yes; but should it, for a sane man, make quite such a difference as this? No. And it wouldn't for a man whose faith had been real faith and whose concern for other people's sorrows had been real concern. The case is too plain. If my house has collapsed at one blow, that is because it was a house of cards. The faith which 'took these things into account' was not faith but imagination. The taking them into account was not real sympathy. If I had really cared, as I thought I did, about the sorrows of the world, I should not have been so overwhelmed when my own sorrow came. It has been an imaginary faith playing with innocuous counters labelled 'Illness,' 'Pain,' 'Death,' and 'Loneliness.' I thought I trusted the rope until it mattered to me whether it would bear me. Now it matters, and I find I didn't."

A Grief Observed
C.S. LEWIS
(A small monograph written more or less as a diary during and following the terminal illness and death of his wife, Joy, from breast cancer)

ROUNDS at the hospital just weren't a lot of fun this evening. Joy seemed to be missing. That's often the case, of course. But usually, most of the time in fact, if not fun at least one finds them interesting and challenging. Whatever the situation, the occasion of reviewing our work, our cognitive or technical efforts, presents to us an enviable if not joyous encounter with people who trust us. I continue to have difficulty understanding our peers who say to me, "I'm retiring. It just isn't fun anymore." I hear those remarks so often these days — "It just isn't fun anymore." And when I ask them why, ask them

where the fun escaped to, if ever it was there, they cite the government or the insurance company. "Surely," I say to myself, "surely, something as nebulous, as contradictory and disorganized and poorly informed concerning the practice of medicine as the government can't destroy the pleasure of a meaningful medical or surgical practitioner."

"I'm thankful for the practice of medicine and the joy it has provided. Thankful even for the sorrow, for that has provided insight not granted to many in the course of their daily work."

But about hospital rounds tonight, sure enough the "fun," even the interest and the challenge, were missing. She lay there in bed, listless and pale and discouraged, as the malignant process crept silently through her body. It was now 3 years since we found the sarcoma in her pelvic organs. The tumor had even then found its way to the lungs but cleared surgically from the pelvis and then stymied with ever-changing chemotherapeutic regimens, she had continued to function at a high level of emotional stability and physical capability. Had continued to work a full schedule at her job with the chemotherapy pump hung from her waistband. I had admired her with that degree of reverence reserved for the few possessed of uncommon courage and self reliance. We had talked freely, comfortably, and frankly today, only this morning, of the gravity of her "situation." We had talked of death, even though in veiled terms, for we both seem to understand that dying is an experience of living that no one should be denied. It is far too valuable, too important and useful, a part of our lives to be allowed to escape us. "I so wanted to be with family for one more Christmas," she whispered. "But you know," she continued, "you know we have had so many good ones, perhaps I can miss this last one. I'm so thankful for all the others." We talked for a while longer, and then the sorrowing husband and I talked in the hall while she slept.

I left then thinking mostly of her courage but thinking also of being "thankful." Thinking also of Christmas and her wish to share one more of these magical holidays with the family she had nurtured for so long.

I'm thankful for the practice of medicine and the joy it has provided. Thankful even for the sorrow, for that has provided insight not granted to many in the course of their daily work.

I'm thankful for Ellie and all of the other medical wives who have shared our sorrow, tolerated our moods and, God bless them, stuck by us when leaving would have been easier and perhaps preferable.

I'm thankful for Miss Sally who after 40 years has decided that the thief who stole away her only child in marriage is going to be alright after all. She now understands that "behind every successful man stands a surprised mother-in-law."

I'm thankful for Glover Copher who taught me as a struggling resident that, "it's not what you eat but what's eating on you that makes the difference," and that regarding the desperately ill patient I could "take away everything from them but never take away their hope." And, in those same years, I'm thankful for Carl Moyer who looked over my shoulder one day at a 2″ incision and told me to close it with 40 stitches, then left me to figure out that it couldn't be done.

I'm thankful for Robert Shaw and his many years as musical director of the Atlanta Symphony even though he failed to convince me that there is pleasure and harmony and melody in music composed and played by a computer.

I'm thankful for Ferrol Sams and his ability to put the human condition into words so understandably even if he did introduce my wife to the vocabulary and the habits of my youth so carefully hidden these many years.

I'm thankful for John Stone who saw the need to introduce medical students to the study of ethics, for he knew that the remainder of their lives, if successful, would require that knowledge — and because he not only saw that need but met it in the medical curriculum at Emory.

I'm thankful for Hugh Wood who as Dean at Emory told me that it is "better for a patient to have a doctor than for a doctor to have a patient." In the competitive world of today, we need to remember that.

I'm thankful for Melvin Foster, he trusted me as his doctor, who told me that "you have to keep your spirits up, Doc. If you don't do that, you might be doing pretty well but you wouldn't know about it."

I'm thankful for the "Ladies" who run my office, for they are the means by which my patients first judge me and because they do that with so much sophistication, caring, and concern that I reap benefits at times not deserved — and because, whether deserved or not, they seem to feel that I am worth working for.

I'm thankful for Medicare and Medicaid, forgive me dear conservatives, for they have provided a level of health care and most importantly of dignity and security to the poor and the elderly even though wasting precious resources on the unneedy. I have confidence that we will yet make common sense

of both of them, though in the process they try our patience, and indeed our patients, severely.

I'm thankful for Mrs. Ross, our High School English Teacher, who gave me an "F" in English igniting a level of shame which led to the winning of the DAR award for the most improved English student the next year. She taught me not only commas and periods but also humility.

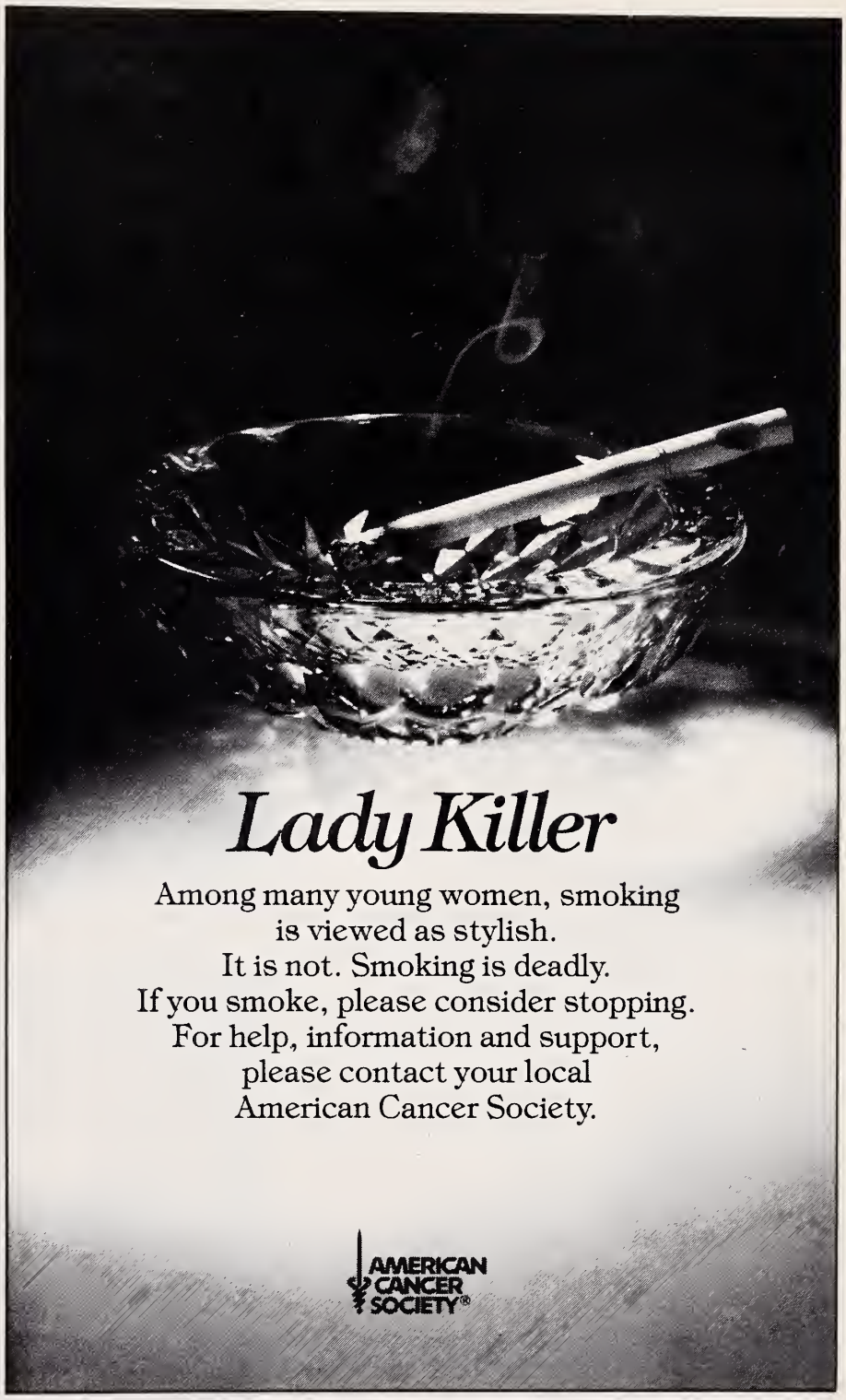
I'm thankful for Rick and Laurie and Jim and Bill and Rob for more reasons than a parent can list, but mostly perhaps because they have each in their own way made me proud of them and in doing so let me think that I was a part of their success.

I'm thankful for Our Lady of Perpetual Help Home, the hospital where they care for terminal cancer patients until they pass away from us, because they see in people only suffering humanity and not cleanliness or education or sophistication or finances.

I'm feeling better now —
Mary is going to be okay —
I know that —
Her husband and her children, there are seven of them, know that —
Of most importance, Mary knows that.

They all have possession of the most magical, the most meaningful, perhaps the most valuable talent any of us could desire — they have the joy of appreciating their past years together and the firm conviction that no government, no third party payor, can take that joy from them. They have the courage to face the trials of today and the common sense and wisdom to know that should Christmas 1990 arrive without Mary, no one can take away the memories of Christmas past. They are thankful for them all. They want me to wish you a MERRY CHRISTMAS.

CRU



New "Yardstick" Needed to Gauge Hospital Capacity Utilization

Editor's note: The following remarks are taken from a recent editorial column by Carol M. McCarthy, president of the American Hospital Association.

A patient from the 1970s visiting a hospital today would find a strikingly different facility. Walk-in diagnostic imaging, cardiac catheterization, ambulatory surgery, adult day care — all these services and many more were developed in the past 10 years in response to changing health needs, advances in technology, and economic pressures.

Many of these new services are provided in areas where acute care beds once stood, and many are designed to prevent illness rather than to treat acute conditions. A few statistics tell the tale. Between 1983 and 1990, hospitals reduced their beds by 7.6 percent, their average length of stay by 5.2 percent, and their average daily census by 14.9 percent. In contrast, outpatient visits increased by 34.1 percent and are now the source of almost one-quarter of hospital revenues.

Less illuminating, however, is the key statistic we have been using for decades to describe hospital capacity utilization: the inpatient occupancy rate. The number of beds has long been viewed as the measure of a hospital's capacity. The percentage of its beds that are occupied on an average day has been widely used as a measure of its use of that capacity — and sometimes of facility efficiency. But given the shift to ambulatory care, this expression of resource utilization is now obsolete.

Continued reliance on the measure is misleading and can be harmful. It lends unmerited credence to charges of hospital inefficiency and fuels national policy decisions that have prevented adequate financing of hospital care.

Even as a measure of inpatient demand, the overall occupancy rate falls short today. For example, the term "staffed beds" is used sometimes to refer to licensed beds, sometimes to beds that could be staffed for patient care on short notice, and sometimes to beds that actually are staffed at the time of counting. Moreover, when beds are unoccupied, they too easily are labeled "excess," a term implying — incorrectly — that eliminating the beds always will increase hospital efficiency and reduce costs.

In many hospitals, unoccupied beds are held ready to meet widely fluctuating patient demand. In others, the "empty" beds deliberately are retained on the hospital's license although the space is allocated to necessary ambulatory care and support programs. In still others, "empty" hospital beds are spread across diverse, non-interchangeable units that, as a whole, are operating efficiently. An unused psychiatric or obstetrical bed, for example, cannot substitute for a needed surgical bed.

A meaningful way must be found to calculate and to express overall utilization in the contemporary hospital. Early this year, the American Hospital Association began developmental work on a system of measurement designed to capture the range of activities — both inpatient and outpatient — that mark the hospitals of the '90s. Major centers of patient care — laboratories, operating rooms, diagnostic imaging, outpatient clinics and emergency departments — all are being assessed along with inpatient bed use, comparing the maximum use possible with figures on actual use.

This summer, the AHA pilot-tested the new measure in a group of hospitals. We now are refining the calculations before a second round of testing. Our goal is a measurement system that is useful to hospital managers as well as to policy-makers and others with an interest in resource utilization.

As hospital managers become familiar with the new measure, they should find it a useful tool for identifying patient care bottlenecks and for facilitating the efficient delivery of services. And as policy-makers and the media have a more accurate yardstick of hospital capacity utilization, "occupancy" no longer will be a way of judging — and often misjudging — hospitals.

More Non-MDs Eligible for Medical Staffs

A growing number of hospitals' medical staff bylaws allow non-physicians to be considered for staff membership, according to preliminary survey findings released by the American Hospital Association.

The 1989 poll of 3,400 hospital CEOs showed that podiatrists can apply for membership at 67 percent of the hospitals, up from 50 percent in 1984. About 43 percent of the hospitals will consider clinical psychologists for membership, up from 32 percent five years earlier. Only 5 percent of the hospitals polled provide medical staff membership for chiropractors, but that figure is up from 2 percent in 1984.

Although non-physicians can be granted staff membership at many hospitals, fewer facilities allow them to admit patients on their own authority, and most prohibit non-physicians from holding elected medical staff office.

The survey also identified several sources of conflict between hospitals and their medical staff members, including quality assurance activities, external regulations, physician recruitment and concerns that physicians are competing with hospitals.

ARMY RESERVE MEDICAL PROFILE NO.9

Dr. Holwick outside of hospital where she practices as a civilian traumatologist.

Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.; University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital; Huntington Memorial Hospital, Pasadena, California; Traumatologist, Arcadia Methodist Hospital, Arcadia, California.

OUTSTANDING ACHIEVEMENTS Borden Freshman Prize; Alpha Lambda Delta; Phi Beta Kappa; Phi Kappa Phi; Bovard Award; ALD Award; American Institute of Chemists Medal Award; Summa Cum Laude, University of California; Alpha Omega Alpha.

"When you enter private practice, the only cases seen are usually those limited to your specialty. Serving as a physician in the Army Reserve offers me a departure from my daily routine. I can be involved in virtually anything I choose. If a certain case interests me, I can ask to be part of the surgical team. If I wish to spend time teaching students, I have that option, too.

"As a Reserve physician, I've had the opportunity to interact with different people, from various backgrounds, with assorted medical and social viewpoints. As a result, I've grown as a physician and as a person.

"I spent six months looking into the Army Reserve program before I joined, wanting to make sure that my skill and time would be put to good use. I've been a Reservist three years now, and I still find it extremely rewarding. I have the satisfaction of knowing that I'm serving my country."

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

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Am Fam Phys 1987;36:133-140

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For respiratory tract infections due to susceptible strains of indicated organisms

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Consult the package literature for prescribing information.
Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology
• Slight elevations in hepatic enzymes.
• Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
• Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
• Abnormal urinalysis; elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Striking a Balance

Larry W. Haldeman, M.D.

The following editorial was given as an address by Larry W. Haldeman, M.D., President of the Medical Staff at Kennestone Hospital in Marietta. Dr. Haldeman in a most erudite and sensitive yet forceful manner said some things to this particular Medical Staff that every physician, every hospital administrative person and every patient involved in the health care system of this state need to hear and more importantly pay attention to. Your editor, viewing these remarks as unusually clear thinking, felt that they deserve pubication in your Journal. CRU

THE FACE of the practice and delivery of medical care in the United States has changed drastically over the past 25 years and most certainly will continue to do so in an exponential fashion. Public expectation of health has increased, and the concept of health care access as a right has become commonplace. Technological advancement has brought tremendous progress in virtually every field of care. Once uniformly fatal illnesses are now by comparison routine. Life expectancy has rapidly increased from only about 40 years at the turn of the century to over 75 years today and continues to rise.

The public, health professionals, and governments have rapidly endorsed this technology and have applied it with little reservation. This application has resulted in tremendous benefit but has also created a population of chronically marginally compensated individuals who require ongoing care at substantial, frequently massive cost.

Simultaneously, as physicians and hospitals have become cloaked in technology, their perceived role as benevolent and beloved healers has been eroded. Many factors have probably contributed to this, including increased population density, deterioration to some extent of interpersonal relationships, subspecialization within the health care field, and the evolving litigious nature of our society.

From this stems an attitude of distrust of the healing profession that occurs in the face of unprecedented demand for its services. This distrust has fostered an attitude in the emerging health care policymakers that if the "bad" physicians and hospitals can only be controlled that cost in dollars will be curtailed in a major way with little, if any, impact on the quality of care. This flies, I believe, in the face of the reality of true increases in demand for services and the fact that only a comprehensive national program of what will amount to rationing of care combined with vigorous preventive public health measures and tort reform will ultimately lead to a true meaningful reduction of cost.

One of the effects of the implementation of these policies to date has been the development of a schism between hospital administrations, their respective institutions, and medical staffs.

The hospitals see increasing regulation and shrinking profit margins threaten their very survival. With limited exceptions which surely will become more rare, they see the day-to-day practice of medicine by their own physicians as fiscally destructive.

Physicians at the same time see an unprecedented demand for sophisticated services, delivered in a caring and compassionate way, with strong emphasis on efficiency, quality, and lack of real or even perceived error. They also see increasing intrusion into their role a decision makers without concomitant dilution of their responsibility and accountability for those decisions. Finally, they see real or potential erosion of the disposable income or, at a minimum, decreasing financial reward for increasing workload.

The result of these forces has been polarization of administrations and medical staff. In the jargon of the legal profession, we have irreconcilable differences, but unlike many marriages there is a true symbiotic relationship between hospitals and physicians that precludes "professional divorce."

So what does the future hold for us? I suspect, unfortunately, only continued crisis intervention until gradually it becomes politically expedient to develop a national consensus and a meaningful strategy. In the meantime, which may well be the rest of our professional lives, I call upon all of you to try to reach a more peaceful coexistence.

I call upon the administration to be alert and sensitive to the special evolving needs of physicians for the efficient and productive use of their skills in the care of their patients.

I call upon the medical staff to be sensitive to the fiscal responsibility of hospital administrators and to recognize

Dr. Haldeman specializes in pulmonary diseases. His address is 54 Tower Rd., Marietta, GA 30060.

that they also suffer under the effects of an untenable system which is in the process of evolution.

And finally, I call upon all concerned to understand that we *will* disagree at times because of the very nature of our positions. But if we can try to set aside private agendas, posturing, greed, and veiled or not so veiled threats, and if we can deal with each other in a courteous and professional manner, then despite diversity of opinions and needs, perhaps we can make the best of a difficult situation for ourselves and for our patients.

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AN EARLIER CHRISTMAS

The roll of dust on the slopes, mist in the valleys,
The crisp night air, the lonely campfires burning,
Sheep huddled against the hill, shepherds sleeping —
A single star in the darkened meadow of sky, —
And God looks down on this long forsaken land,
Barren, dry, rock-strewn, and boulder-scarred,
Saying: "I'll send my Son to give them hope,
Hope to this land, this desert of soul and soil!"

God sweeps away the clouds; the star brightens,
And bathes the weary herders as they sleep.
The sheep grow restless; shepherds rise to their bleating
To follow the star through the ever-wakening night —
Traveling the tortuous way from Nazareth,
The donkey feels a firm hand on the reins:
And Mary, alighting in Bethlehem, must know
The weight she bears is no ordinary Child!

In the dank, dark stable, with single candle glowing
And the Baby cuddling against his mother's breast,
God smiles! He knows that, for all its grief and pain,
The world will never be the same again!

JOHN RANSOM LEWIS, M.D.

HANUKKAH

Menorah candles
Light the night
And brighten the eyes
Of children singing.

A feast of lights
Warms the hearts
Of children grown,
Their songs still ringing.

The oil of Judea
Has lasted long
In hearts and minds
And hopes still winging.

LULLABY FOR CHRISTMAS TREES

Sleep, little spruce pine,
Bend your boughs low!
Then Christmas tree hunters
Won't want you so.

Quiet, little cedar,
Maybe these elves
Will let you grow larger
To make closet shelves.

Hush, little hemlock,
Sigh in your pillow!
Someone will think
You're a weeping willow.

Wait, little holly,
Hold up your head!
Their truck is stuck
In the creek bed.

Look at the heavens,
A snowstorm's in store!
Maybe we're safe
For one Christmas more.

Dr. Lewis, a plastic surgeon in Atlanta, is Georgia's Poet Laureate.

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The Future is in our hands?

Saturday, Sunday
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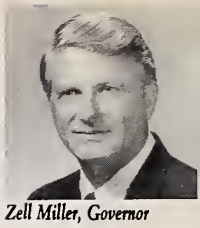
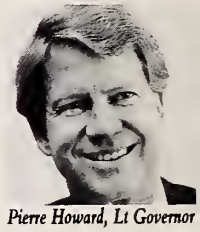
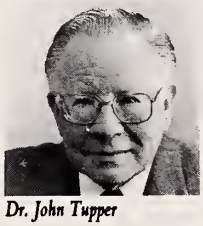

Zell Miller, Governor


Pierre Howard, Lt Governor

The Honorable Zell Miller, Governor of Georgia will announce his administration's new agenda for meeting the state's health care needs in the nineties.


Dr. John Tupper

John C. Tupper, M.D., President of the American Medical Association, will focus on "Health Access America," the AMA's dramatic 16-point program to meet the nationwide call for health care changes, while keeping the best features of American fee-for-service medicine.

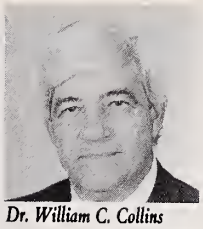
Professor Paul Star of Princeton, author of The Social Transformation of American Medicine, *will reflect on how physicians can still retain their professional autonomy despite the coming of the corporation.*

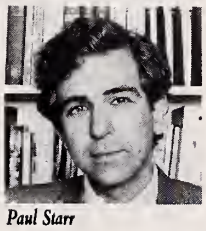
Point-Counterpoint Two Visions of an Ideal American Health Care System. Dr. Nicholas E. Davies, of Atlanta, President-Elect of the American College of

sicians will be sharing podium with John C. dman, Ph.D., of las, President of National Center for cy Analysis. They be presenting natically different views American medicine, and t the country's health delivery system ought to lanning for.

Ralph Crawshaw, D., is founder of Oregon lth Decisions, the nization founded several s ago to help Oregonians ess opinions on their 's health care system. gon Health Decisions played a key role in loping the "Oregon " of prioritizing cal services for limited licaid funding. Dr. vshaw currently serves inical professor of hiatry at Oregon Health ices University.

The Honorable e Howard is the newly ed Lieutenant Governor eorgia. He will be nting his views on the h care system in gia, and outlining his s for upcoming service r State.


Dr. William C. Collins


Paul Starr

Dr. Nicholas E. Davies

Saturday, February 2

9:00 a.m.
Welcome, Introduction,
Governor Zell Miller
Dr. William C. Collins

9:15 a.m.
My Goals for Georgia's Health Care in the 90's
Governor Zell Miller

9:45 a.m.
Questions and Discussion

10:00 a.m.
Response of the Medical Association of Georgia
Dr. William C. Collins, President

10:10 a.m.
The Coming of the Corporation: How Physicians Can Maintain Autonomy
Paul Starr, Ph.D., Princeton University
Author, The Social Transformation of American Medicine

10:35 a.m.
Questions and Discussion

10:55 a.m.
Break

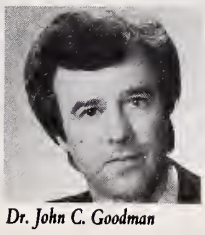
11:15 a.m.
Reform, Not Revolution: the AMA's Prescription for American Health Care
Dr. John C. Tupper, President, AMA

11:40 a.m.
Questions and Discussion

12:00 p.m.
Lunch

1:30 p.m.
Introduction to Afternoon Session: Point-Counterpoint: Working Toward an Ideal Health Care System
Dr. William C. Collins

1:40 p.m.
Dr. Nicholas E. Davies, President-Elect American College of Physicians


Dr. John C. Goodman

2:05 p.m.
John C. Goodman, Ph.D., President, National Center for Policy Analysis

2:25 p.m.
Questions and Discussion

2:45 p.m.
Break

3:05 p.m.
The Oregon Plan: The Ethics of Rationing Care
Dr. Ralph Crawshaw
Oregon Health Decisions

3:30 p.m.
Questions and Discussion

3:45 p.m.
Introduction,
Pierre Howard, Lt. Governor
Dr. William C. Collins

3:50 p.m.
Why the Future is in Your Hands
Pierre Howard, Lt. Governor

4:15 p.m.
Questions and Discussion

4:30 p.m.
MAG's Vision of Health Care in Georgia
Dr. William C. Collins
Dr. Robert A. Burns

4:50 p.m.
Questions and Discussion

5:00 p.m.
Reception

Sunday, February 3

9:30 a.m.
Your Practice as Small Business: Vital Tips You Need to Know
MAG Mutual

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MRI UPDATE

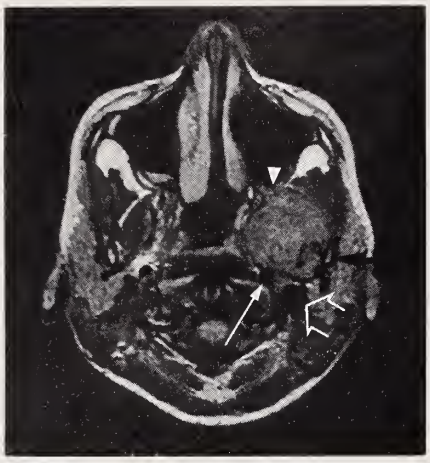

Figure 1

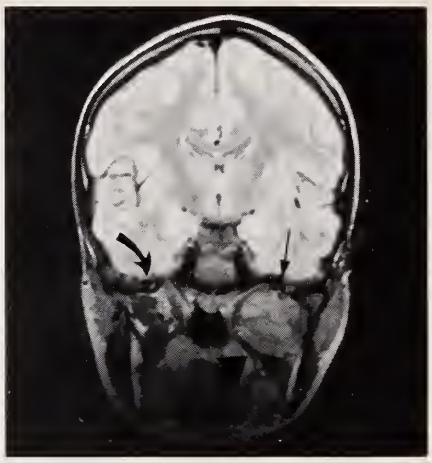

Figure 2

CLINICAL INFORMATION: This is a 14-year-old male with headache and left jaw pain.

FINDINGS: The axial image (figure 1) demonstrates a 4 cm. mass centered in the left parapharyngeal space. It deforms the left nasopharyngeal wall, but the fat plane between the nasopharyngeal wall and the mass indicates that the mass did not arise from epithelium there. The mass extends anteriorly through the pterygopalatine fossa to abut the posterior wall of the maxillary sinus (arrowhead), but it does not appear to invade the sinus. The mass extends laterally adjacent to the neck of the mandibular condyle (large arrow). It is separated from the deep lobe of the parotid by the deep branch of the facial artery. The mass is separated by fat from the internal jugular vein (open arrow). It abuts, but does not encase the internal carotid artery (long arrow). The coronal image (figure 2) demonstrates the mass effect of this large lesion (large arrow). Though the mass lies adjacent to the foramen ovale (small arrow) and appears to engulf an exiting branch of the mandibular nerve, it does not extend intracranially. The mandibular division of the fifth nerve lying just above the foramen ovale is shown on the normal right side (curved arrow).

COMMENT: MRI clearly demonstrates the size and extent of the mass in this difficult location. CT does not provide the multiplanar capability and soft tissue detail afforded by MRI which provides complete presurgical staging and analysis. The differential diagnostic possibilities must include juvenile angiofibroma because of the patient's age and sex. Paraganglioma and schwannoma were also considered possibilities. Mixed tumor arising from the deep lobe of the parotid could produce this appearance, but the lesion appeared to be separate from the deep lobe. The biopsy diagnosis was "sarcoma". Rhabdomyosarcoma in this area more commonly occurs in younger children.

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Quality Predoctoral Training in the Ambulatory Setting

W. Douglas Skelton, M.D.

QUALITY IN MEDICAL education is not easy for me to define. Hopefully, it differs from the "quality" and "excellence" which characteristically are used to describe most proprietary health care services. I've been more enamored of such words as "adequate" or "useful," particularly if they are backed by data. Nonetheless, it is clear, I believe, that our personal assessment of an educational experience as having quality depends to some degree on the values or beliefs we hold about the goal of medical education.

I describe the goal of medical education as the production of caring and competent physicians who are committed to independent and lifelong learning. Caring means valuing people, empathizing, feeling and demonstrating compassion and personal sensitivity. Competent means a certain level of understanding of biological, psychological, and social influences on human behavior in health and illness. A competent physician will have an understanding of the difference between a profession and a business, including the social role and responsibilities of physicians, and will value and practice independent learning.

Our personal assessment of an educational experience as having quality depends to some degree on the values or beliefs we hold about the goal of medical education.

The great teaching hospitals have made major contributions to medical education. They will continue to do so even as they become less suited for many aspects of clinical education. As medical care continues to move out of the hospital, medical educators have found it difficult to structure an integrated and coherent learning situation which allows a student to follow a problem from identification to outcome.

Practicing physicians report themselves as unprepared for ambulatory practice. The inpatient focus has limited our students' recognition that most illness is chronic illness which is best treated and learned about over time in an ambulatory setting. Decision theory, clinical epidemiology, communication skills, and ethics are among the issues promoted for the ambulatory setting. Frankly, they are issues for any settings where patient encounters occur. Certainly, an ambulatory setting is a better site for examining the cost and benefits of the increasing intensity of medical services than the hospital where many forces encourage the use of high intensity care.

The need for greater exposure of medical students to ambulatory care

Dr. Skelton is Provost for Medical Affairs and Dean, Mercer University School of Medicine, 1400 Coleman Ave., Macon, GA 31207.

has been included in several recommendations for change in medical education. The GPEP Report[1] and the Macy Foundation Report on Clinical Education and the Doctor of Tomorrow[2] are noteworthy examples. Moore,[3] in the latter report, called for the development and dissemination of a 2-month primary care/general medicine curriculum emphasizing *the acquisition of basic competencies necessary to the effective practice of office medicine (ambulatory care) in all specialties.* This same belief or view was important in the deliberations of the Society of Teachers of Family Medicine work group which developed Curricular Guidelines for a Third-Year Family Medicine Clerkship.[4]

Teaching in the ambulatory setting has not been very popular in the past. It has been characterized as dealing with trivial problems (the worried well), expensive, unacceptable to patients, and poor preparation for residency. Unfortunately, and principally for lack of all the things needed to have a successful program, many ambulatory care programs operated with little or no orientation of the student and few instructional experiences designed to meet specific educational goals. Feltovich et al made the point clearly, "Exposing students to ambulatory care is not the same as educating them in ambulatory settings."[5]

An effort was made in the 1950s to improve education in ambulatory care settings. Several schools developed comprehensive medical care programs which were well received by students and were as effective educationally as traditional programs. Perkoff[6] ascribed their failure to lack of departmental ownership, i.e., the clinical faculty were "on loan" from other departments, and there was a gradual loss of faculty to the lure of biomedical research dollars and specialty practice dollars. Federal financial incentives in both of these areas have discouraged education in ambulatory settings.

Quality/adequate/good/useful/efficient education in the ambulatory care setting must be designed to meet specific educational goals. Outcomes must be defined and evaluated. The program design, i.e., timing in the curriculum, length of the experience, number and mix of faculty resources, etc. differs for goals as diverse as introductory history taking and continuity of care. Remember the "Q" in quality. Question everything. Why are we doing this? What do we expect the student to learn? How is progress to be assessed? What attitudes may develop? What values might be reinforced or challenged?

Woolliscroft and Schwenk[7] stress the need to recognize that ambulatory care settings are organized more for the convenience of the patient (or should be) and that the patients are more independent. They have non-patient identities, jobs, deadlines which they have not set aside to assume a passive, patient role. The educational experiences must be designed with these differences in mind.

There is a broad range of teaching and learning goals possible in ambulatory settings, whether in primary care of specialty medicine. There can be greater exposure to undifferentiated problems, to highly differentiated problems not often seen in hospitals, to the natural or treated history of an illness, to clinical epidemiology, to decision analysis, to the development of communication skills. These goals and many others which are best pursued in ambulatory settings are critical to developing future physicians to meet patients' needs in the evolving health care system.

To assure quality in the ambulatory care educational experience requires attention to the important aspects of all education experiences. These are identified goals, appropriate instructional methods, reliable evaluation systems, and a feedback system for correction or change. These things are not simple. Assessment is a complex area and instructional methods, e.g., reading lists, patient contact, use of simulated patients, and computer assisted learning need constant attention.

Decision theory, clinical epidemiology, communication skills, and ethics are among the issues promoted for the ambulatory setting.

But quality education in the ambulatory setting requires other things to be successful:

1) The commitment of senior leadership. Students gear what they study to how they are evaluated. Institutions respond to the values of their leaders. There must be a willingness of leadership to articulate the value of education in the ambulatory setting, advocate for it, support it with resources, and protect it from enemies.
2) Curriculum change may be necessary. A few schools, my own included, have developed with specific missions to produce primary care physicians. Most have recognized that beginning medical students are not yet biased against ambulatory care or primary care. The curricular response is to focus on ambulatory care early with exposures to patients in community settings and efforts to learn population-based approaches to community care. The goal is to support and to encourage primary care

choices. The content is substantial and important. Not stated, but important, is the message that the sciences basic to medicine are biological, behavioral, sociological, psychological, epidemiological, i.e., that knowledge, opportunity, and intellectual challenge exist in ambulatory care as well as in high technology, hospital intensive settings, and specialties.

This message has to be continued with quality ambulatory care components in the third year core or required clerkships. Psychiatry, dermatology, and other principally outpatient specialties have in many schools developed very good programs. Some of these experiences have been reported. Gutmann[8] describes a 20-year required ambulatory care neurology experience at West Virginia University which was begun due to the lack of neurology residents. His comments on the advantages of such a program can be extended to other subspecialties. The advantages for education are the larger number and variety of illnesses and more experience with the course of serious disorders. After 20 years he concluded the experience is best when only students and faculty are involved. Residents were reported as not clear how much to delegate, i.e., not experienced enough to assess what students could do alone, could do while supervised, or should not do under any circumstance.

There is evidence that the piggy-backing of medical student education onto graduate medical education may be serving U.S. medical education poorly.

Now, from my experience to date, I believe family medicine is the model for quality ambulatory care at the predoctoral level. I'm sure there are good programs in the other primary care disciplines, i.e., general internal medicine and general pediatrics. However, Feltovich's[5] review was not very encouraging as regards internal medicine, and both general internal medicine and general pediatrics are struggling for support within their parent specialty. Under the best of circumstances, ambulatory care experiences in internal medicine, pediatrics, and other specialites, cannot substitute for a 6-8 week ambulatory care experience in family medicine, especially if the program is developed with the goals and core competencies described in the Society of Teachers of Family Medicine's Curricular Guidelines for a Third-Year Family Medicine Clerkship.[4] Unfortunately, only about 50 of the 126 medical schools have required family medicine clerkships in the third year. Hopefully, the Curricular Guidelines will stimulate new programs as well as enhance existing ones.

For many schools, attention to the faculty reward system will be necessary. Promotion of faculty involved in ambulatory care has been a problem. Kosecoff et al[9] noted that fewer than 25 percent of faculty in the General Medicine Group Practice Program funded by the Robert Wood Johnson Foundation reported two or more publications a year. At Mercer, we have a teacher-clinician track which requires scholarly activity but not publications.

I believe some of the problem is value oriented. Innovation and creativity by faculty are needed in developing programs in the ambulatory setting. Professional and economic rewards need to follow such activities. This is again a leadership problem. It needs to be pointed out, however, that educational innovations, from design to evaluation, need to be in the literature. There is little excuse for not writing about these things.

Residents have always been viewed as important in the education of medical students. A "ladder of learning" is described as progressing from faculty to resident to student. Residents are expected to be faculty for students. Despite vocal proponents, there are no data linking resident involvement in teaching to improved medical student learning. In fact, when those of us who don't have residency programs in all the disciplines compare student performance between clerkships with resident involvement or without resident involvement, no differences are noted.

I am convinced that with proper management, the costs of education in the ambulatory setting can be accomodated through the usual payments generated by the hospital teaching clinic.

On the contrary, there is evidence that the piggy-backing of medical student education onto graduate medical education may be serving U.S. medical education poorly. Schwarz et al[10] in a 1990 study of clinical education in Canada, the United States, and the United Kingdom showed senior faculty of U.S. schools doing the least amount of clinical teaching: 25.1% versus 33.6% for Canada, and 47.3% for the U.K. U.S. junior faculty do slightly more at 31.7% but again less than Canada at 44% and U.K. at 36.7%. Most troubling is that residents are reported as doing

43.2% of all clinical teaching in the U.S. For Canada, the resident percent is 22.4; for U.K., 16%. The authors felt this finding was related to U.S. deans being dissatisfied with the evaluation of clinical skills of medical students. This was in contrast to the Canadian and United Kingdom deans.

The issue of residents as teachers in ambulatory care settings must be explicity addressed. More senior residents may be able to function like faculty. To do so, they need to have their faculty responsibilities clearly identified, to be supervised and assisted in their faculty role, and to be aware of the need for their assessments to be as objective as possible. They are, however, not essential to the quality of the education experience and may impede it. Our medical students value clinical experiences not encumbered by the presence of residents. I expect the view is not unique among U.S. medical students.

Money and space are also issues for education in ambulatory care settings. From the mid-sixties to 1988, federal funds for teaching and research have dropped from 55% of medical school funds to 24%. During the same period patient care revenue moved from 6% to near 40%. In many schools, there is considerable pressure on faculty to see more and more patients. Some see this as impeding more educational experiences in ambulatory settings.

All I can conclude from this is that things are tough all over. I am convinced that with proper management, the costs of education in the ambulatory setting can be accomodated through the usual payments generated by the hospital teaching clinic. Kassebaum[11] and Kosecoff et al[9] have addressed the issue of costs, space, and faculty and staff time. Productivity tends to favor the resident and faculty mix above certain minimum numbers, and faculty supervision requirements for residents may be overstated. Faculty and staff time and space availability analysis showed more expansion capability than generally acknowledged.

Our principal teaching hospital just financed a feasibility study of combining the school-based family practice group with the hospital-based group in a new location with adequate space for medical student and resident education. The consultants project a break even in 2 years if hospital-generated revenues are considered and in 4 years without hospital revenues. To do so assumes continuing Medicare reimbursements, state residency capitation grants for family medicine residents, and the same ratio of faculty salary participation by Mercer. The point needs to be made that what will work for Mercer may not work elsewhere, and that national health policy goals, i.e., more training in ambulatory care settings, are not likely to be successful without uniform funding incentives.

In summary, quality training is possible in the ambulatory setting at the predoctoral level. Like training anywhere, there needs to be attention to goals, expected competencies, and assessment. Institutional support is necessary, and curriculum and faculty reward systems will require attention. Space, time, and costs need to be carefully assessed.

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Global Health Care: A Look at the Future

Louis W. Sullivan, M.D.

Louis W. Sullivan, M.D., U.S. Secretary of Health and Human Services and a member of this journal's editorial board, speaking at the Second Japan-United States Health Care Symposium. Dr. Sullivan spoke of the need to train physicians to understand and provide quality health care from a global perspective. He stressed the need of individuals to take personal responsibility for their health.

THIS CONFERENCE provides a model for international exchanges between health care professionals, which can serve as valuable supplements to large, multinational forums such as the World Health Assembly. Greater international consultation and cooperation will be necessary to improve the quality of health care throughout the world as we approach the 21st Century.

Health care professionals from all countries must strive to learn more about each other and about each other's health care systems — and to share each other's knowledge. I look forward to the development of more such exchanges.

It is vital because, in this age of instant communication, rapid travel and multinational trade, health care is truly a global concern. We now realize that diseases can pass quickly from country to country and from continent to continent. Rapidly expanding trade makes available new foods, medicines, and technology which can greatly affect health care. So, developments in another country or continent can no longer be dismissed as someone else's concern.

Dr. Sullivan is Secretary of the U.S. Department of Health and Human Services and a member of the editorial board of the MAG Journal. This article is taken from his remarks at the Second Annual Japan-America Health Care Symposium held October 10, 1990, in Atlanta.

MAG President William C. Collins, M.D., addressed attendees at the Symposium. He explained "state's rights" with regard to physician licensing — a new concept for Japanese physicians who are licensed nationally.

I am deeply committed to improving health care here in the United States, and to working with other countries to improve the health status of all people. President Bush and the Congress have ordered comprehensive studies of our health care system, and the President has asked me to present options for reforms when I have finished reviewing their recommendations and the work of my own Department.

This evening, I would like to share with you some of our ongoing efforts which, I believe, will be of interest both here at home and beyond our borders.

In many nations, including our own, lifestyle and behavior greatly influence the incidence of disease and death. Poor nutritional habits, tobacco use, abuse of alcohol and illicit drugs, must be addressed.

So, in addition to our relevant domestic and international health programs, I have asked for the creation of a climate of personal responsibility, urging Americans to live healthier lives, to reassert the importance of individual character, and to develop a culture that nurtures values and self-discipline through an emphasis on disease prevention and the promotion of healthy lifestyles.

I am working with our medical schools to train physicians who are better equipped to provide quality health care and to understand health care from a global perspective. I have asked them to prepare physicians who are well trained in communication skills and problem solving, as well as the basic sciences and clinical medicine. I have called for an increased emphasis on primary care fields and more attention to the needs of our poor and minority citizens in medically underserved communities.

And — I have challenged our medical students to become "Renaissance Physicians."

Physicians in the 21st Century will practice medicine in a much different world. They must be not only technically competent and knowledgeable in the basic and clinical sciences, but also life-long learners, excellent communicators, good businessmen, and health care visionaries.

Physicians must work continually to strengthen their interpersonal skills. So often I hear patients, and health care professionals themselves, comment on the inability of some physicians to listen carefully to, and then talk clearly with patients, as if the patient is only another case study, and not a person who may be confused, frightened, and in need of a friend. This will become even more critical as, more and more, the patient may be of another country, culture and language.

We must never forget that so much of our work depends on a thorough understanding of the patient, his or her environment, his values, hopes and fears — and that requires effective communication. The physician must learn from the patient, and then help the patient — motivate the patient — to effectively fight illness. This is central to the successful practice of medicine.

To assist physicians, other health professionals, and patients in making informed decisions, we have undertaken a research program to study the effectiveness of various medical treatments for health problems such as heart disease and cancer. We want to know more about which treatments are most effective — to enable us to improve the quality of medical care and maximize the utilization of our resources. The results of this research could benefit the people of all nations.

We have also made a stronger commitment to biomedical research in our public health service. This research will help us deliver more effective and less costly treatment, vaccines, or a cure for

devastating diseases. This information can help us all address health needs around the globe.

One project that interests me especially is our effort — involving scientists from around the world — to map the human genome — literally to understand the information encoded on a human chromosome. Our National Institutes of Health are actively involved in this project. Clearly, such as effort will benefit all mankind.

Gene mapping will help us understand inherited disorders. It could lead to new strategies for the prevention and treatment of more than 3,500 diseases of known genetic origin, and to a much better understanding of other diseases that have genetic components, such as infectious diseases, cancer, depression, and hypertension.

The neurosciences provide another promising area for research in the coming decade. President Bush has designated the 1990s as the Decade of the Brain. This emphasis on brain research will further stimulate neurologists and scientists to work together worldwide on research to address diseases of the central nervous system.

As part of our biomedical research effort, we are fighting to further understand and address HIV infection here in the United States and around the world. We are exploring every promising lead to find a cure and to develop a vaccine.

We are working to form a greater partnership between public and private research. For example, the laboratories in several public health service agencies are collaborating with industry scientists in joint research projects under cooperative research and development agreements, as encouraged by the Federal Technology Transfer Act of 1986.

At the Food and Drug Administration, we have established an Office of Biotechnology to provide a focal point for cross cutting biotechnology issues related to product development. The National Biotechnology Policy Board was created to review and apraise the non-confidential work of the private sector, as well as the activities of the federal government in this field.

In addition to Dr. Louis Sullivan (R), Harrison L. Rogers, Jr., M.D. (L), MAG Past President, and W. Daniel Barker, Director of Hospitals, Emory University, also attended the Health Care Symposium at the Nikko Hotel in Atlanta.

I have asked our medical schools to prepare physicians who are well trained in communication skills and problem solving, as well as the basic science and clinical medicine, and who understand health care from a global perspective.

Two years ago, Congress established the National Center for Biotechnology at the National Library of Medicine to create automated systems for storing and analyzing knowledge about molecular biology, biochemistry, and genetics. The Center will coordinate efforts to gather biotechnology information worldwide.

We have implemented a number of initiatives at the Food and Drug Administration which have substantially reduced the potential development and approval times for new drug products.

These improvements have included streamlining the application process for new drugs and encouraging applications by computer — eliminating cumbersome requirements and giving researchers much greater freedom to adapt clinical studies in the early phases of drug testing. Our FDA staff work with sponsors in the early phases of clincial trials, to help assure clinical studies that obtain meaningful data in a timely fashion.

While none of FDA's changes may appear revolutionary, their collective results have yielded real progress. For example, total new drug applications which are overdue

We must first build the bridges necessary for mutual understanding between countries. We must listen to each other's views, learn each other's needs, understand each other's values, and respect our differences.

have reached their lowest level in 5 years. Several important new drugs for cancer, AIDS, and other serious diseases have been approved in a very short time.

Exosurf, a drug for treating hyaline membrane disease in premature infants, was approved in the near-record time of 5 months.

We have also been accepting more foreign studies and working with foreign companies to assist in the design of studies in their countries that would be acceptable at FDA.

Ladies and gentlemen, we can — and we must — make every effort to generate a sustained, dramatic increase in the health status of citizens in all countries. But to accomplish that, we must first build the bridges necessary for mutual understanding. We must listen to each others' views, learn each others' needs, understand each others' values, and respect our differences.

This is exactly what is taking place here, between esteemed professionals — and friends — of two great countries. I trust that significant progress will be made toward helping us provide better health care to the citizens of our two countries at home, and when visiting or living in each other's country.

I ask that you share the cooperation and friendship on display here with your colleagues throughout the world. Thank you.

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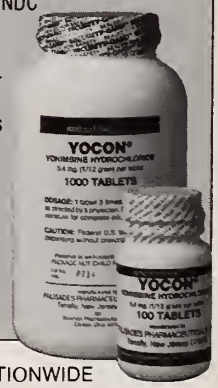

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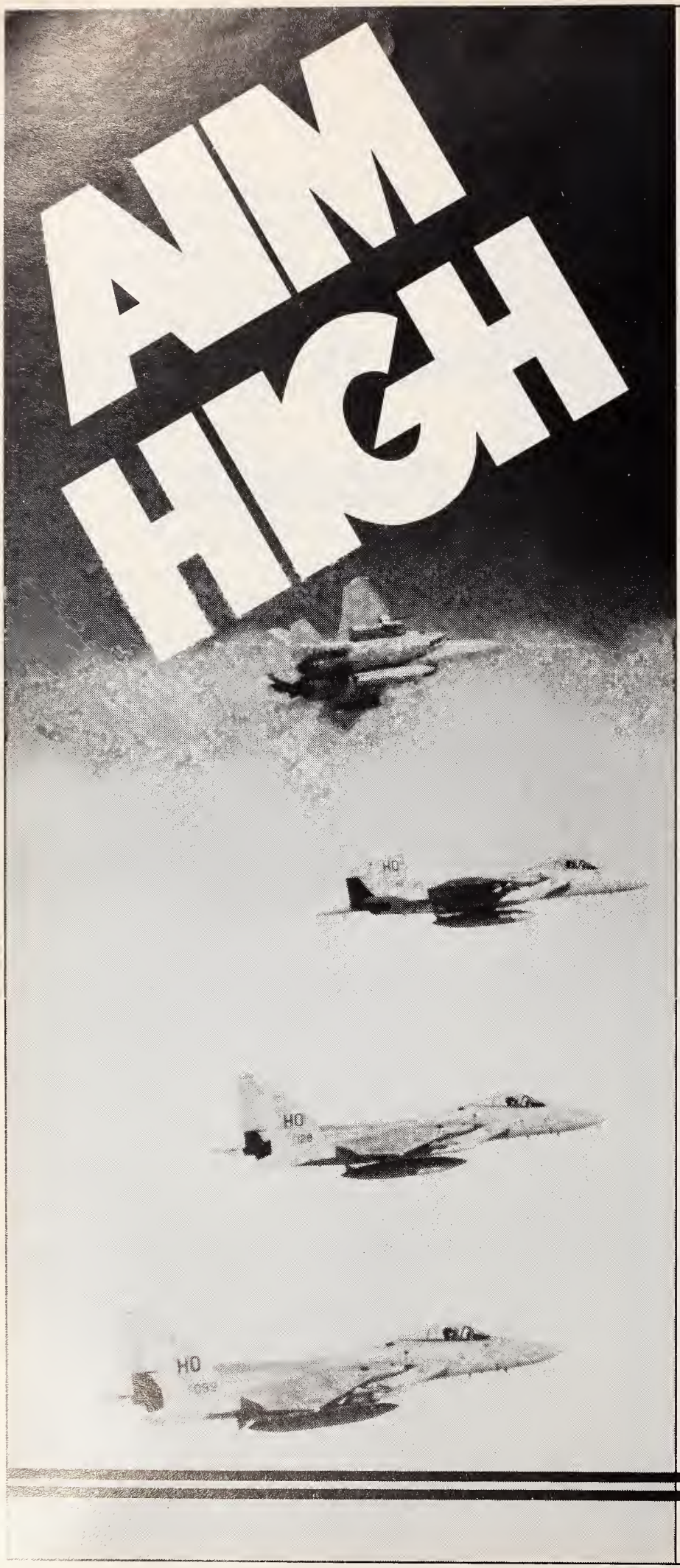

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Domestic Violence: An Analysis of Battered Women in Georgia

Jennifer Branch-Rooke, M.D., Thomas W. McKinley, M.P.H., R. Keith Sikes, D.V.M., M.P.H.

Introduction

DOMESTIC VIOLENCE is not only a tragic event in the lives of victims, it eventually involves many aspects of health and social services.[1] As the leading cause of injuries among women in the United States, domestic violence is estimated to require more medical treatment than rape, motor vehicle crashes, and muggings combined.[2] Moreover, children who witness violence between their parents are more likely to perform poorly at school and have behavioral problems.[3,4] In addition to being at greater risk of being abusive or abused in future relationships, these children are at increased risk for problems in adulthood such as alcoholism, mental illness, criminal behavior, and early death.[3-5]

While battered women's shelters provide relief in crisis situations, their role in decreasing future violence is difficult to assess. Long-term benefits appear to depend heavily on the motivation of the women seeking shelter.

A recent study in Atlanta showed that 27 of 135 (20%) homicides during 1984 were committed by a relative or intimate partner of the victim. According to Atlanta Police records, at least 25% of perpetrators for both fatal and non-fatal intentional assaults had a history of prior police contact for family and intimate assaults.[6] Moreover, approximately 60% of fatal victims had a history of one or more contacts with at least two service sectors, defined as criminal justice, health, mental health, or social service agencies.[7]

The annual incidence of battered women in Georgia has been conservatively estimated to exceed 250,000; although surveillance methods are inadequate to make a precise determination of the true extent of the problem. In 1989, there were 38,714 calls to the various battered women's crisis lines in Georgia. Also in 1989, the Department of Human Resources (DHR) reported that battered women's shelters throughout Georgia served

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24,558 abused women, 2,697 of whom were admitted. The agency estimated that over 50% of the women who sought shelter were turned away for lack of space.[8]

The characteristics of the women who seek shelter in Georgia, the frequency and severity of their abuse, and the extent of their contact with human service agencies in the public sector are not well known. In order to gain a better understanding of these factors, records from Georgia's battered women's shelters were reviewed and a one month survey was conducted to gather descriptive information on the population sheltered.

A detailed analysis of these data are being reviewed within DHR. The most salient features of the analysis which reflects on battered women as a portion of the domestic violence problem in Georgia were chosen for presentation in this article.

Methods

Records Review

A retrospective review was conducted of records of the Georgia Network Against Domestic Violence (GNADV) for the period 1986-1989. Historic data regarding the number of shelters, the number of women requesting shelter, and the number of women sheltered were analyzed.

Questionnaire Survey

Questionnaires designed to be administered to each battered woman on admission to the shelter were developed by members of the Data Subcommittee of a multi-agency Task Force on Domestic Violence with the assistance of the DHR Office of Epidemiology. After field testing and refinement, questionnaires together with detailed instructions on completing the forms were mailed to the 23 battered women's shelters that were operative in Georgia at the time of the survey. During the week of October 23, 1989, telephone contacts were made with key staff members at each shelter to explain the importance of accurately completing questionnaires. Shelter staff were asked to use the questionnaires as part of their admission procedures for the month of November, 1989, only. Completed questionnaires were forwarded through GNADV or Division of Family and Children Services (DFCS) to the Office of Epidemiology for data entry and final analysis. Shelter staff were also asked to record the total number of admissions and the number of persons who were turned away during the month.

Results

Women Requesting Shelter

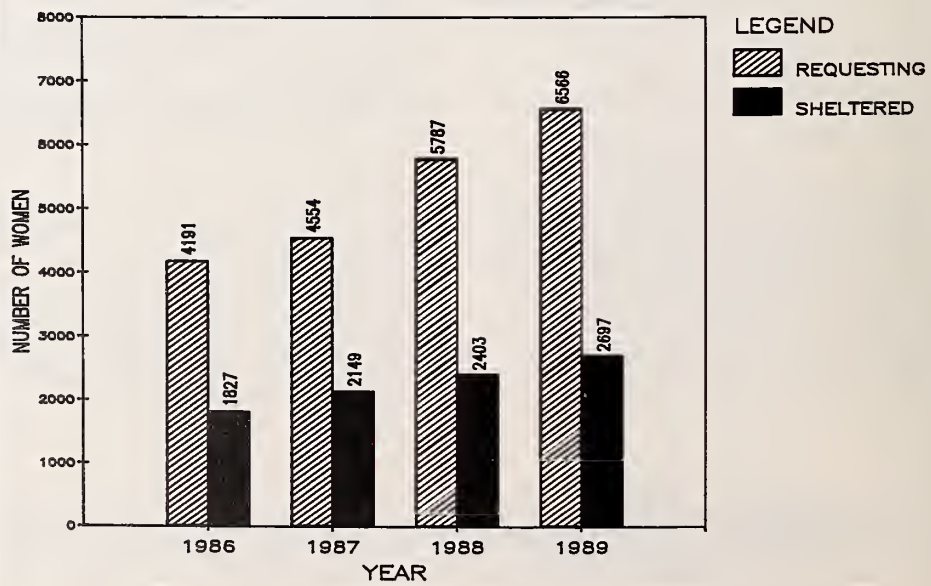
Review of records for the 4-year period 1986-89 indicated that 21,098 women with 23,734 children requested admission to battered women's shelters. It should be noted that these data reflect only documented requests. The actual number is believed to have been higher since shelter personnel sometimes failed to record requests if the shelter was full or if the woman was referred elsewhere. Shelter was actually provided for 9,076 (43%) of requesting women and 11,421 (48%) children. There was a steady increase in the number of women requesting shelter and the number receiving shelter annually during the 4-year period reviewed (Figure 1).

Participation

Of the 23 shelters receiving questionnaires, 21 (91%) shelters returned one or more completed forms. Shelters from which forms were returned will be referred to as "participating" shelters; those from which forms were not returned will be referred to as "non-participating." A total of 210 admissions (193 to participating and 17 to non-participating shelters) were recorded during November, 1989. The 21 participating shelters actually returned questionnaires on 151 battered women. Of these, 137 (91%) were sufficiently complete to be analyzed. Thus, the overall response rate for all 23 shelters was 65%.

The number of admissions for all participating shelters ranged from one to eleven per day, so that on any given day during the month of November at least one woman was admitted to a battered women's shelter in Georgia. Tuesdays had the highest mean number of admissions (5.75 per day); Saturdays had

FIGURE 1 - NUMBER OF BATTERED WOMEN SHELTERED AND REQUESTING SHELTER GEORGIA, 1986 -1988



the lowest (2.25 per day) (Figure 2).

Demographic Data

Age. Demographic data for battered women and their abusers are shown in Table 1. The median age of women was 29 years; range 16-56 years. Abusers were slightly older. Their median age was 33 years; range 19-64 years. The majority of both groups were between the ages of 20-39 years.

Race. Almost two-thirds (63%) of the women were white, and the remainder were black. Women reported that 58.1% of their abusers were white, 39.7% black, 1.5% hispanic, and 0.7% other. The majority of abused women were of the same race as their abuser.

FIGURE 2 - AVERAGE NUMBER OF ADMISSIONS TO SHELTERS BY DAY OF THE WEEK BATTERED WOMEN

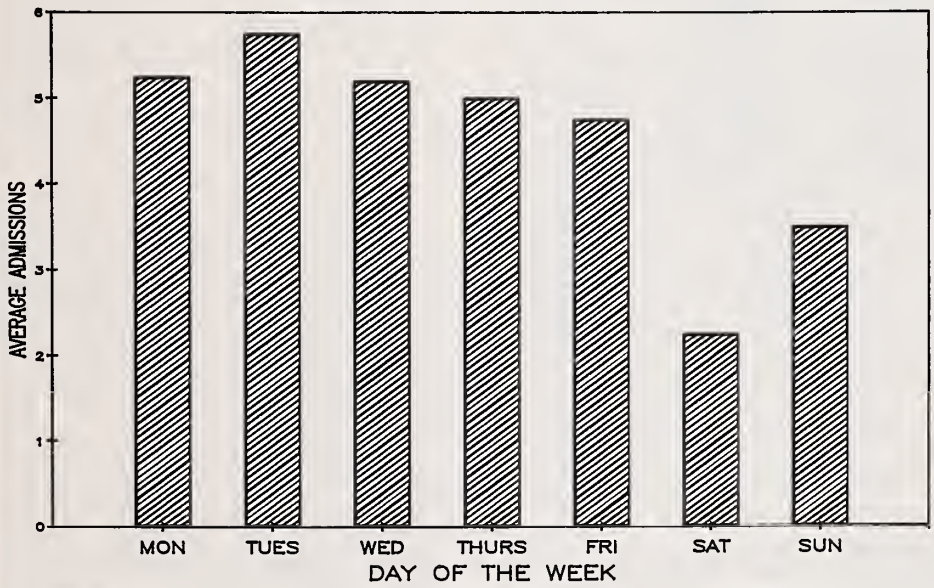
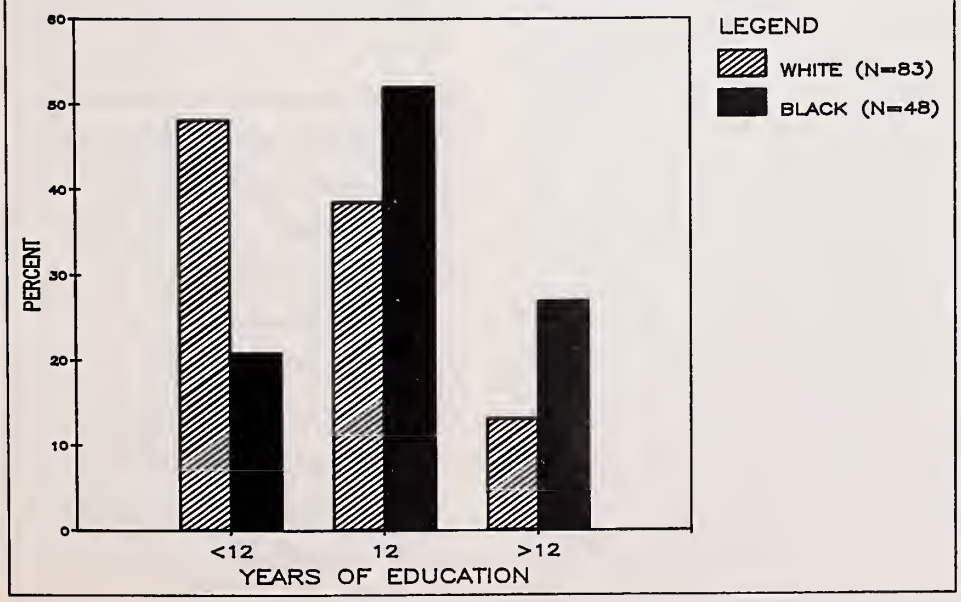


FIGURE 3 - PERCENTAGE DISTRIBUTION OF BATTERED WOMEN BY YEARS OF EDUCATION AND RACE



Residence. Of the 129 women who responded to the question regarding state of residence, 119 (92%) were from Georgia. Length of residence in the state ranged from 1 month to 56 years, median 15.3 years. However, 16% of the sample had resided in Georgia for less than 1 year, and 22% for less than 2 years. The county from which the highest number of women were admitted to shelter (16; 13% of the total) was Fulton. Data were not available regarding residence state or county of abusers.

Education Level. The median education level for women and their abusers was 12 years, although ethnic differences were observed for both groups. A significantly higher proportion of black compared to white women ($p = 0.005$; chi-square test) reported 12 or more years of education (Figure 3). The same was true for black compared to white abusers ($p = 0.012$; chi-square test) (Figure 4).

Occupation

Information on occupation was not obtained for women entering the shelters; however, women were requested to provide information on the occupation of their abuser. More than one-fifth (21.7%) of the 120 abusers whose occupations were reported were currently unemployed; 52.5% were employed in blue-collar jobs, 11.7% in service occupations, 8.3% in white collar jobs, and 2.2% in active or retired military service. Another 1.5% were students and 1.5% were described as drug dealers.

Marital Status

The majority (64%) of women were married to their abusers (Table 2). The average length of the relationship with the abuser was 6.1 years, with a range of 4 months to 36 years. However, over a third (39%) of the sample had been together for less than 4 years.

Children

Approximately three-fourths (76%) of the women had one or more children. Of the 224 total chil-

TABLE 1 — Demographic Data

Battered Women		*Abuser*	
Age (N = 135)		Age (N = 126)	
Median	29 yrs.	Median	33 yrs.
Mode Group	20-39 yrs.	Mode Group	20-39 yrs.
Range	16-56 yrs.	Range	19-64 yrs.
Race (N = 135)		Race (N = 136)	
W	63.0%	W	58.1%
B	37.0%	B	39.7%
		O	2.2%
Sex (N = 137)		Sex (N = 137)	
F	100%	F	0.7%
		M	99.3%
Residence State (N = 129)		Residence State (N/A)	
GA	92.2%	Not available	
Other	8.8%		
Education Level (N = 133)		Education Level (N = 121)	
Mean	11.5 yrs.	Mean	11.4 yrs.
Median	12 yrs.	Median	12 yrs.
Range	6-18 yrs.	Range	3-20 yrs.
≥Hi Sch Grad	61.7%	>Hi Sci Grad	60.3%
Occupation (N/A)		Occupation (N = 120)	
Not available		Blue Collar	52.5%
		Service	11.7%
		White Collar	8.3%
		Unemployed	21.7%
		Other	5.8%

dren, 187 (83%) under age 18 were brought to the shelter with their mother (Table 3).

Abuse Data

Of the 134 women who provided information regarding onset of abuse, 50 (37%) reported that the first incident occurred within the past year. An additional 28% reported that the first incident was within the past 1 to 3 years (Table 4). Abuse first began 3 or more years ago for 35% of women. The most recent incident of abuse was within 3 days prior to coming to the shelter for 66% of women. Weekly abuse was reported by 46% of the 130 women who responded to the question on frequency and another 36% reported monthly abuse.

Physical abuse was the reason given by 95.5% of the women for coming to the shelter while the remaining 4.5% stated that physical abuse was threatened. Sexual abuse was reported by 34% of women surveyed, and another 4% reported that sexual abuse was threatened.

Physical and sexual abuse were reported by women less frequently for children than for themselves. Of the 104 women who had children, 16 (15%) stated that their children were physically abused and 8 (8%) reported that their children were threatened with physical abuse. Sexual abuse of children was reported by two (2%) women and one (1%) reported that their children were threatened with sexual abuse.

Injuries

Of the 135 women who answered the question on physical injury to themselves as a result of domestic violence, 118 (87%) said they had been injured by their abuser; 84% more than once and 29% more than 10 times. Medical care from a private physician or hospital emergency room was sought by 54% of the injured women, and 16% required hospitalization. Of the women reporting physical injury, 20% stated that they were rendered unconscious, and 18% reported that their injury required stitches. Miscarriages or problem pregnancies were attributed to abuse by 12% of injured women, 33% reported fractured or broken bones, and 10% stated that their injuries were permanent in nature.

Contacts with Public Agencies

Of the 137 women included in the survey, 48 (35%) had contact with one or more DHR agencies prior to their abuse. The agencies most frequently contacted were the DFCS (65%); the Division of Public Health (DPH) (29%); and the Division of Mental Health, Mental Retardation, and Substance Abuse (MHMRSA) (21%). A greater proportion of women (56%) had contact with one or more agencies after the onset of abuse than before. Moreover, these agencies were frequently aware of the abuse (Table 5).

Discussion

Based on available data, there is a far greater demand for beds than available bed space within battered women's shelters in Georgia. During 1986-1989, only 42-44% of women who requested shelter actually received it.

While battered women's shelters provide relief in crisis situations, their role in decreasing future violence is difficult to assess. Long-term benefits appear to depend heavily on the motivation of the women seeking shelter.[9] For some women the first shelter stay is the step that frees them, but for most it takes many admissions before they either leave their abuser or he ceases to be abusive.[10,11] When

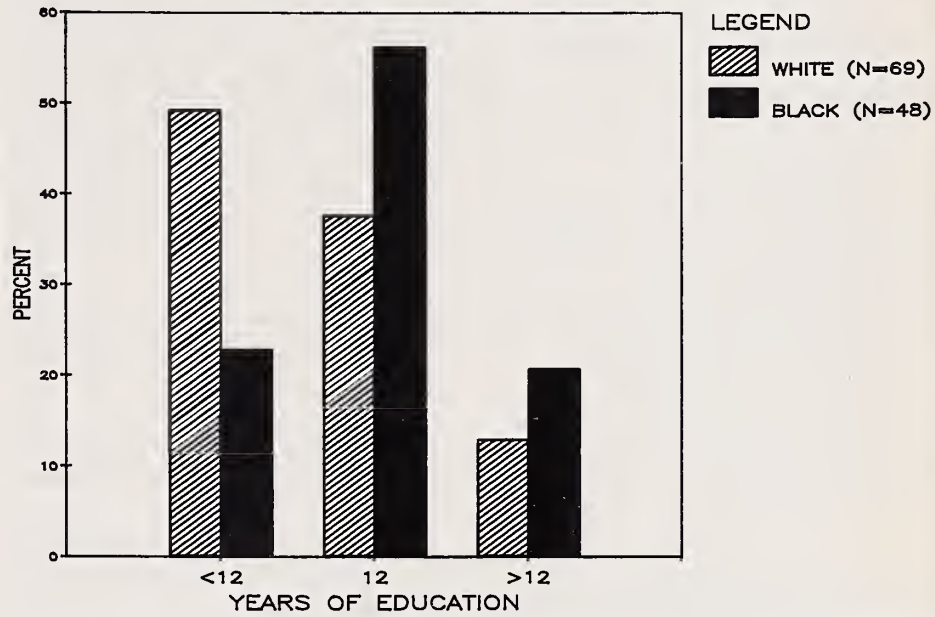
It is quite possible that increased police and DHR staff sensitivity and standardized protocols for recognizing and dealing with violent relationships could reduce the number of fatal events.

shelter stay is perceived by the abuser as a serious attempt to leave the relationship, violence escalates in a small number of cases; but, for most, it decreases dramatically.[9] The shelter stay is more likely to be perceived by the abuser as a serious attempt to leave when the woman has engaged in previous help seeking behavior such as agency contact.[9] Regardless of her intention upon admission, the services and psychological support received by the woman at the shelter often increase her self-esteem and awareness of alternatives and additional sources of help.[10, 12]

These data suggest a need for improved sensitivity on the part of agencies to be alert to the possibility of abuse plus a better system for receiving and following up on reports of abuse. It is quite possible that increased police and DHR staff sensitivity and standardized protocols for recognizing and dealing with violent relationships could reduce the number of fatal events. Police Foundation research shows that abusers who are arrested after the first incident are less likely to be repeat offenders. Atlanta Police records, however, indicate that few arrests are ever made after the first incident.[6] Whether or not the abuser is arrested, early intervention, counseling, and follow-up are necessary to prevent domestic violence from increasing in frequency and severity.[13]

Shelters are usually a last resort for women who have no where else to go. Women are often reluctant to request family or friends to take them in for fear of jeopardizing the safety of these loved ones.[10] Moreover, battered women frequently are without relatives or close friends in the area. A technique of abusers is to isolate their victim. The relative importance of isolation of battered women in Georgia may be reflected in the fact that almost a quarter of the sample had been resident in the state for less than 2 years. Our mobile society often increases the victim's isolation and the need for more shelters.

FIGURE 4 - PERCENTAGE DISTRIBUTION OF ABUSERS BY YEARS OF EDUCATION AND RACE



The battered women's shelter is a short-term refuge from a violent or potentially violent situation, but all women who seek shelter in Georgia do not gain entrance. Lack of space is only one reason for denying admission. Most shelters operate on a very limited budget with minimal staff. Women who are admitted to shelters must be self-sufficient, i.e., physically and mentally able to care for themselves and their children. Battered women with substance abuse problems are often not

TABLE 2 — Relationship of Battered Women to Abusers

Relationship	*Number*	*Percent*
Husband	84	61.3%
Common Law Husband	13	9.5%
Boyfriend	21	15.3%
Ex-Husband	7	5.1%
Ex-Boyfriend	4	2.9%
Separated	3	2.2%
Other	5	3.6%
	137	100.0%

TABLE 3 — Age Distribution of Children Brought to Battered Women's Shelters by Their Mother

Age	*Number*	*Percent*
< 1	29	15.5%
1-4	70	37.4%
5-9	59	31.6%
10-14	24	12.8%
15-17	5	2.7%
TOTAL	187	100.0%

These reports indicate the impact of domestic violence on the health care system and the need to involve physicians and emergency room staff in detecting and reporting domestic violence as part of any strategy for prevention and control.

considered appropriate candidates for admission to shelter due to the lack of staff with substance abuse expertise. This represents a serious gap in services to women who are experiencing both violence and addiction. Under present circumstances a mentally ill, battered woman would also likely be denied shelter admission due to the lack of adequate, trained staff to deal with the problems of mental illness. An additional reason why women may be denied admission to shelters is if they pose a risk to the safety and security of others in the shelter due to their own assaultive behavior or the potential violence posed by their abuser. Finally, a woman that has other options such as family, friends, or other living accomodations would be denied admission.

A significantly higher proportion of black than white women reported completing 12 or more years of school. Based on 1980 census data, one would have expected the proportions with 12 or more years of education to be approximately equal for both racial groups.[14] Educational attainment does not necessarily relate as well to economic status among blacks as among whites. A black woman in our society is more likely to have a lower income than a white woman of the same educational level. This may partially explain the educational difference which was observed. Given less financial resources, better educated black women who come to shelters probably have fewer options open to them such as money to hire an attorney to help secure a protective order from the court.

Child abuse appeared to be underreported in the Georgia survey. Approximately 15% of women stated that their children were abused, and almost 8% reported that their children were threatened with abuse. In contrast, a study of violence in 8,145 families indicated that approximately 50% of fathers who frequently abused their wives also abused their children and 20-40% of battered mothers, in turn, abused their children.[15] Moreover, another study in a population of 60 battered women indicated that fully one-third of children had been physically or sexually abused.[16] Underreporting in the Georgia survey is believed to have resulted from fear of possible loss of custody of the children. Women are informed on admission to the shelter that staff are required by state law to report all cases of child abuse to DFCS.[17] Children are not always taken from the family of abusers, but the fear exists.

Almost a quarter of the women reported that their abusers were unemployed. This finding is consistent with the literature which indicates that employment status is an

TABLE 4 — Abuse Data

First Incident Began (N = 134)	
<6 months ago	18.7%
6 months to 1 year	18.7%
1 to 3 years	27.5%
3 to 10 years	26.1%
>10 years	9.0%
Most Recent Incident Before Shelter (N = 137)	
<24 hours	45.2%
1 to 4 days	20.7%
4 to 8 days	12.6%
8 to 30 days	14.8%
>30 days	6.7%
Frequency of Abuse (N = 130)	
Weekly	46.2%
Monthly	36.2%
Semi-annually	14.5%
Yearly	3.1%
Injury (N = 135)	
Physically Injured (N = 118)	
Frequency (N = 116)	
Once	16.4%
2-4 times	32.7%
5-10 times	21.6%
>10 times	29.3%
Medical Care (N = 118)	
Physician or ER	54.2%
Hospitalized	16.1%
Not Stated	29.7%
Severity of Injury (N = 118)	
Physician or ER (N = 64)	
Unconscious	25.0%
Stitches	20.3%
Hospitalized (N = 19)	
Unconscious	26.3%
Stitches	42.1%
Not Stated (N = 35)	
Unconscious	8.6%

important variable in abusive behavior among men.[10, 18]

The vast majority of women who came to shelters reported that they had been injured more than once by their abuser, and most had seen a doctor or visited an emergency room. These reports indicate the impact of domestic violence on the health care system and the need to involve physicians and emergency room staff in detecting and reporting domestic violence as part of any strategy for prevention and control.

Approximately half of all the women in the sample indicated that they had been in contact with one or more human service agencies at some time, either before or after the onset of abuse. DFCS was the agency most often contacted by victims after onset of abuse, and almost two-thirds of these battered women indicated that DFCS was actually aware of the abuse. More data are needed regarding what steps, if any, were taken to protect the women when the agency was aware.

An underlying question raised by these data is what motivates women to seek shelter at a particular point in time? Do they seek shelter when it is most convenient or when they feel most threatened? Two-thirds of the women had been abused for 4 to 10 years. It is important to know how many times in the past they had sought shelter, what their post-shelter plans were, and what impact, if any, did the shelter stay have on their lives. These are areas for future study.

TABLE 5 — Battered Women With Agency Contact After Abuse and Agency Aware of Abuse

Agency	*Number Reporting Contacts After Onset of Abuse*	*Number (%) Reporting Agency was Aware of Abuse*
DFCS	61	39 (63.9)
MHMRSA	21	14 (66.7)
PH	14	4 (28.6)
CPA	8	4 (50.0)
YS	2	2 (100.0)
RS	2	2 (100.0)
OTHER	14	14 (100.0)

Acknowledgements

Due to the urgency of dealing with domestic violence, a multi-agency group called the Domestic Violence Task Force (DVTF) was formed. A presentation was made to the Department of Human Resources (DHR) Management Team who expressed the need for more data. As a result, the DVTF Data Subcommittee undertook this descriptive study of women admitted to battered women's shelters. It is hoped that these data will assist in forming the foundatin for programs to better address the critical area of domestic violence in Georgia.

The authors wish to thank the following persons on the DVTF for their contribution to this study: Margo Smith — Georgia Network Against Domestic Violence; Jane Mahone — Council on Battered Women; Sarah Brownlee, Beth Carroll, Qiyamah Rahman, Betty Wrights-Robinson — Division of Family and Children Services, DHR; Marion Brown, Susan Deaver, Betty Goddard — Division of Public Health, DHR; Lee Martus, Nancy Record, Charlotte Thompson, Dr. Alan Ziglin — Division of Mental Health, Mental Retardation, and Substance Abuse, DHR; Winton McNair — Division of Rehabilitative Services, DHR; Angela Powell-Smith — Division of Youth Services, DHR; Mary Lou Mandell — Office of Aging, DHR; Evelyn Lerner — Office of Regulatory Services, DHR; Don Barash, Don Mathis — Office of Community and Intergovernmental Affairs, DHR; Vicki Elisa — Public Affairs, DHR. Special thanks is also due the women and shelter staff who participated in the study.

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My Ideals for the Medical Association of Georgia

J. O. Elrod, M.D.

The Medical Defense feature of our Association, which is the best protection any physician can have from damage suits, is one of the greatest benefits derived from being a member, especially if measured in a financial way.

FIRST, that every County in the State be organized in some way.

Second, that we have a hundred per cent membership of eligible physicians in the State.

Third, that we maintain and publish the best Medical Journal of any state in the Union.

Fourth, that our Medical Defense Committee have fewer damage suits to defend every year.

Fifth, that our Association will be strong enough to educate the public through its membership of the dangers of cults and charlatans, until the public will drive the last of them from the borders of our State.

Sixth, that our Association through our Public Policy and Legislation Committee may be able to convince the State Legislative bodies that our organization should be consulted in regard to Health laws and appropriations.

Why should we have every County in the State organized? The County Society is the only portal of entrance to any Medical Organization. Why? Because the physicians in each county know the character of and qualifications of the other physicians in their county better than any committee from a State or a National Organization could possibly find out. A County Society, being the portal of entrance to all other Medical Organizations, may be able to make an upright ethical practitioner of a physician who might be inclined to be unethical in many ways. In this way fraternalism will be promoted among all the physicians in a county, whereby their strength in health matters will be a power, where combined efforts will not allow criticism. The County Society should have public meetings dealing with Health subjects and if any physician in a community or county does not take some part in these meetings, the public begins to inquire why he is not affiliated with his County Society. Times have changed; there was a time when to be a member of a Medical Society was to belong to a Trust, but today the public demands that you keep abreast with the times, and they realize that to do this you must belong to your various medical organizations.

We are not advertising when we have public meetings; they are always for the good of the county where they are held. The programs should be varied, consisting of scientific papers pertaining to Public Health, possibly a talk by some prominent laymen. In connection

Dr. Elrod, from Forsyth, was President of the Medical Association of Georgia in 1924-25. This article was published in the January, 1925, issue of this Journal.

with all this there should be some social affair. The above outlined program will keep your County Society an interesting one and will educate the public in health matters. I realize that this cannot be carried out in some counties in our State as in some there is only one physician and in others only two or three physicians. In this case, two or more counties may combine and have a live organization. Your church, your social or golf club does not pay you a cash monthly dividend; you get out of either of them just what you put into them; but your County Society, which you help to keep active, will contribute to your success in every phase of life, whether religious, business or social. Your County Society pays back to you just what you put into it; if you do not attend and take interest you get nothing from the society. Each county society should have an active Secretary, for the Secretary means more to the success of the society than any other member. He should be a man who is not easily discouraged, so if one meeting is a failure he will not give up, but try harder to make the next meeting a success. The members should stand by their Secretary by giving him every support possible.

When every county in a District does its best and maintains a good society, your District Society will be a success and be a great benefit to all, but more to some physicians who may not be able for some reason to attend the State meetings. I wish at this time to appeal to every County Society that has not held its December meeting to call a meeting at the earliest possible date, elect officers, collect dues and report the meeting to our Secretary with accurate information as called for on the report blanks mailed out by him. This will give him an accurate directory of the State. Remember also that it is just as easy to pay your dues now as later and helps our Secretary a great deal in getting his files in order without a rush before April the first, as this is the last day you have to pay them and receive the protection of the Medical Defense feature of our State Association.

The Second Ideal depends on what I have already said in regard to the county societies, as the membership of the Medical Association of Georgia depends on the activity of its County Societies. The average percentage of membership in the United States is about 60 per cent, our average at present is 54 per cent. Georgia stands twelfth as to number in the states, seventeenth as to total number belonging to State organizations, but lamentably forty-third in percentage. States that are lower in percentage are Arkansas 51.9 per cent, Oregon 50.8 per cent, New Mexico 50.4 per cent, Florida 38.1 per cent, District of Columbia 26.3 per cent. Our border states Tennessee 53 per cent, South Carolina 66.9 per cent, Alabama 78.8 per cent, Florida 38.1 per cent, North Carolina 74.3 per cent; Florida being the only one lower than Georgia. Why this state of affairs? We offer more for dues of $5.00 than any other State; Organization, Medical Journal and Medical Defense. Why is it every physician is not a member? Is it, first, Ignorance of benefits; second, Indifference; or, third, Have we more quacks or ineligible physicians than other states? I am inclined to think the first classification prevails. Then if this is true you who know the benefits of our State Organization must be missionaries and explain the many benefits to your brother practitioner, who is not a member. First, the fellowship which we gain by being members together and associating with each other; Second, the knowledge which we obtain from scientific papers read at the meetings and printed in our Journal, as well as the personal exchange of ideas while in personal conversation; Third, the influence which being a member of the various organizations may give you with the general public. Our organization is able to promote Public Health ideas with a combined profession which does not allow criticism.

Our Medical Journal is one of the best in the Southern states.

The Medical Defense feature of our Association, which is the best protection any physician can have from damage suits, is one of the greatest benefits derived from being a member, especially if measured in a financial way. During my time as President of our Association I have found from visiting the various District Society meetings, that a good number of members do not realize they are being protected by this feature of the Association. A full explanation of the protection that is given you by our Association is printed on the back of your membership card. I think it might not be amiss at this time to tell you of the work this Committee on Medical Defense has done since 1920. They have had seventy-seven suits brought against our members, which amounted to $1,500,000 in claims. They have settled fifty-five of these claims with only one member having to pay any damages, the amount he paid being $35.00, which he said he had rather pay than have to attend court. This case cost our Association $400.00 besides the services of our regular paid Attorneys, with no expense to the defendant except the $35.00 damages which he paid. They still have twenty-two cases pending, which amount to $250,000. The Committee hopes to settle a good number of these cases out of court as they did in the fifty-five they have settled. The protection is worth a great deal more to you than protection by an Indemnity Company, which would cost you several times the amount of your dues to the Medical Association of Georgia. Should you have a damage suit before the majority of juries and they know that you are

protected by some Indemnity Company, they would say, "Oh, we will give that fellow some damages, it will not cost that doctor anything," never considering how much they are damaging your reputation. On the other hand if they know that the entire Medical Association of Georgia is defending your reputation and that if any damages are awarded you will be the loser both financially and in reputation, they will be more careful in rendering a verdict. To have this protection your dues must be received by the Secretary of the Medical Association of Georgia before April the first of each year. If you have paid your dues and do not receive your membership card within a reasonable time you should write our Secretary, as he is always very prompt to mail out membership cards when dues have been received. To be sure of your protection pay your dues at once, procrastination is responsible for a great many losses.

The Third Ideal, I trust we will all do our best the coming year to make good. How can we do this? By sending in all news items that may be of interest to the physicians of our State, personals, public health items, notice of Society meetings, including programs, etc. Send in well written scientific papers. We can help in a financial way by helping the advertising department. Inquire of salesmen who call on you if their company carries an Ad with our Journal, try to buy from those who do advertise in our Journal, and mention their Ad when ordering from them. Remember it takes all of these things to make a good Medical Journal.

My Fourth Ideal may be achieved by every physician being careful not to criticise his brother practitioner. So often a damage suit is brought against a physician on account of a thoughtless remark of a brother practitioner, who did not intend any damage or criticism when he spoke unthoughtfully. In this connection some of the suits we have had to defend have been against some of our best standing members and brought on on account of the criticism of some thoughtless physician.

The Fifth Ideal can only be achieved by County Societies having Public Health meetings, by writing Public Health articles for your County paper signed by your County Society. By every member of the County Society offering his support to the different lay bodies. If we do not do this the Quacks, Chiropractors and different Cults are going to get on the program of every lay body possible. Unless these lay bodies are told of this danger how are they to know who to choose for their programs?

How are we to accomplish the Sixth Ideal? First, by having a live, good-working Committee on Public Health and Legislation, which I think we have at present. In the past this committee has never had a chance to do any work, a new Committee being appointed every May just before the Legislature convened in June. The revision of our Constitution and By-Laws made this Committee a perpetuating committee; the Chairman being appointed for three years with a new member appointed each year. This Committee can now lay out plans for Public Health Legislation and keep the members of the Association posted in advance what legislation is coming up at the present session of our Legislative bodies. Then by every physician conferring with his Representative and Senator before they leave home to attend these meetings good can be accomplished. Especially should the family physician of these Representatives make a personal appeal to them and show them that any legislation we may ask for will be for the betterment and protection of the health of the State, which is the greatest asset we can have. The United States Government statistics show that Georgia's death rate for 1923 was the lowest of any state in the south-east, being 11.3 per thousand population. Since we are improving along this line let's not lag in our efforts to continue to lower the percentage. When we can show a low death rate and a healthful state then Industries will begin to flock to Georgia, especially since the people of Georgia have voted to exempt them from taxation for five years.

Our State Organization is incorporated under the laws of Georgia, every member has the same amount of stock in the Organization, every member should have the same amount of interest in the Organization to make it a success, as the members are the stockholders, our Councillors are our Trustees, and our Officers are our directors. Our Officers and Councillors are anxious to have the best Association in 1925 than we have ever had and that we will continue to grow until the second Ideal of your President is realized. What will you do? Will you do your part towards making your County a 100 per cent membership of eligible physicians? Speak to those who are eligible and are not members of your Society, explain the many benefits to them. Their membership will help the public and all the physicians in your County as well as strengthen our State Organization in every respect. The officers of our Association stand ready to help you in any way they can, so call us on when we can be of service to you.

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Georgia Supreme Court Mandates Disclosure of JCAHO Accreditation Reports

Susan Cowan Atkinson

IN A DECISION eagerly awaited by the media and Georgia hospitals and closely watched by health care officials across the nation, the Georgia Supreme Court recently held that accreditation reports prepared by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) must be disclosed under certain circumstances by the Georgia Department of Human Resources (DHR), which obtained the accreditation reports from hospitals for licensing purposes. Depending on one's point of view, this may be good news or bad news: good news for consumers of health care services seeking more information on health care facilities, but bad news for those who fear that the ability of hospitals to receive objective evaluations will be damaged by the loss of confidentiality. This interesting case is the subject of this month's Legal Page.

Background

In order to obtain an operating permit, a hospital may either a) undergo an inspection by the DHR, or b) provide the DHR with "the certification or accreditation . . . by [JCAHO] . . . or other accreditation body . . . as evidence of that institution's compliance with the substantially equivalent departmental requirements for issuance or renewal of a permit. . . ."[1] Utilizing the second method is referred to as having "deemed status." In April, 1989, reporters from two newspapers made requests under the Open Records Act[2] that the DHR provide them with access to accreditation reports of all accredited Georgia hospitals. The Open Records Act provides that

All state, county, and municipal records, except those which by order of a court of this state or by law are prohibited or specifically exempted from being open to inspection by the general public, shall be open for a personal inspection by any citizen of this state at a reasonable time and place. . . .[3]

While reports of actual DHR inspections were routinely disclosed, the DHR's written policy[4] had been to maintain the confidentiality of JCAHO accreditation reports. Following an unsuccessful attempt by DHR to obtain permission from Georgia hospitals to disclose the JCAHO accreditation reports submitted to DHR by "deemed status" hospitals, the DHR (with the two involved newspapers joining as intervenors) filed suit in Fulton County Superior Court[5] and asked the court to declare DHR's rights and responsibilities to provide access to the accreditation reports. Ruling on a motion for summary judgment without a trial, the lower court ordered the reports revealed, and the Supreme Court heard the hospitals' appeal.[6]

Supreme Court Refuses to Find Exemption

In attempting to convince the Supreme Court to overturn the lower court's ruling, the hospitals argued that the accreditation reports were generated to provide peer review and were thus exempt from disclosure. The hospitals centered their argument around O.C.G.A. §31-7-15, which requires hospitals and ambulatory surgical centers to engage in peer review to "[reduce] morbidity and mortality and for the improvement of the care of patients,"[7] but also provides an exemption for the records of such peer review from the disclosure requirements of the Open Records Act.[8] In a 5-2 decision written by Chief Justice Harold G. Clarke, the Supreme Court rejected this argument, instead agreeing with the newspapers' assertion that the accreditation reports were provided to the DHR in compliance with state licensing requirements set forth in O.C.G.A. §31-7-3, rather than to fulfill any peer review function.

Similarly, the Supreme Court rejected the argument that the accreditation reports are protected by statute as records of a "review organization." O.C.G.A. §31-7-133 provides that records of a "review organization" shall be held confidential; O.C.G.A. §31-7-131 (3) defines a "review organization" as

Any panel, committee, or organization which is primarily composed of professional health care providers or which provides professional liability insurance for health care providers and which engages in or utilizes peer reviews and gathers and reviews information relating to the care and treatment of patients [for certain stated purposes].

In rejecting the application of this statute to the JCAHO reports, the Court held that the JCAHO does not fit the statutory definition of a "review organization" since it is not primarily composed of "professional health care providers."

This article was prepared at the request of the *Journal*. Ms. Atkinson is an associate in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Road, NE, Atlanta, Georgia 30326. Send reprint requests to Ms. Atkinson.

No Federal Confidentiality Requirement

The Open Records Act itself provided one avenue of attack for the hospitals: O.C.G.A. §50-18-72 (a) (1) provides that "public disclosure shall not be required for records that are . . . specifically required by the federal government to be kept confidential." The hospitals argued that the federal law which makes accreditation mandatory for participation in the Medicare program, and which further prohibits disclosure of any accreditation report by the federal agency involved, protected the records from disclosure under this federal records exception. 42 U.S.C. §1395bb specifically provides that

The Secretary [of Health and Human Services] may not disclose any accreditation survey . . . of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.[9]

The hospitals argued that this federal law provided the directive of confidentiality contemplated by O.C.G.A. §50-18-72 (a) (1). However, the Supreme Court again rejected the hospitals' argument, stating that "there is no requirement under O.C.G.A. §50-18-72 that a report generated by or used by the state for state purposes be exempted from disclosure merely because that report would be kept confidential if generated or used by the federal government for federal purposes." The Court appears to be saying that unless the federal law specifically requires *the state* to keep information confidential, the fact that the federal law requires the *federal government itself* to keep the information confidential will not keep the state from disclosing the information once it is in the state's possession.

Balancing Public Need Against Individual Privacy

The hospitals asserted that the JCAHO reports cannot be disclosed because the written administrative rules of the DHR prohibit such disclosure; however, the Court dismissed this argument in rapid fashion, relying on the general rule that when an administrative agency's rules conflict with a law of general application, the law will prevail. The Court then turned to the hospitals' argument that the lower court's deciding the case *as a matter of law,* without first hearing the facts concerning the relative importance of the "public's need to know"[10] and the hospitals' interest in maintaining confidentiality, was improper.

For over a decade, Georgia courts have typically engaged in a "balancing test" in determining whether or not public records should be disclosed.[11] In performing this test, the judiciary traditionally has heard the specific factual allegations of the parties and then balanced the interests of the public in favor of disclosure (in this case, an increase of information for consumers) against the interests of the public in favor of nondisclosure (here, improved quality of care through confidential peer review); however, in the 1989 case of *Board of Regents v. The Atlanta Journal and The Atlanta Constitution,*[12] the Supreme Court limited application of the balancing test to cases where an *individual's* privacy is involved. Now a court must balance the interest of the public in favor of disclosure against the interest of an individual in personal privacy in determining whether it will issue an order protecting records from disclosure.

In the case at hand, the Supreme Court proved that it is committed to this new type of balancing test. Since in this case confidentiality was sought by institutions rather than individuals, five of the seven justices concluded that no balancing test should take place and that summary judgment without consideration of the facts was proper.

In a written dissent which was joined by Presiding Justice George T. Smith, Justice Norman Fletcher disagreed with the majority on this point, arguing that in the *Board of Regents* case and in this case, the majority has blurred what were previously two distinct tests. Justice Fletcher maintained that the long-used balancing test requires the court to weigh "the interest of the public in favor of disclosure of public records against the interest of the public in favor of nondisclosure, in determining whether public records, which are not prohibited 'by law' from being made available for public inspection, should be so prohibited by court order."[13] While acknowledging that the Open Records Act does provide an exemption from disclosure for records "the disclosure of which would be an invasion of personal privacy,"[14] Justice Fletcher asserted that the pertinent language in a case such as this is found in that section of the Open Records Act which states that all public records, "except those which *by order of a*

"The Court's decision does not specifically indicate whether JCAHO reports not submitted to the DHR are subject to the Open Records Act, and neither does it indicate whether such reports held by hospitals are discoverable in malpractice cases or other litigation."

court of this state or by law are prohibited from being open to inspection by the general public, shall be open for a personal inspection. . . ."[15] Justice Fletcher argued that while the disclosure of records which would be an invasion of personal privacy are prohibited "by law," a separate inquiry under the balancing test must be made by a court in determining whether it will issue an order protecting records. The justice argued that by balancing the public's interest in disclosure against the public's interest in nondisclosure only in cases involving an individual's privacy, the usefulness of the balancing test is effectively eviscerated.

Notwithstanding this argument, the direction of the majority of the court seems clear: it will only consider the facts surrounding the competing interests in cases where an individual's privacy is at stake. In other cases (such as the one at hand), summary judgment without a trial is appropriate. Curiously, however, in the opinion's concluding paragraph, the majority seemed to actually *perform* a balancing test while purportedly revealing the "common-sense" explanation behind its decision: "Since the accreditation surveys in question were presented by the hospitals to the DHR for licensing in lieu of the hospitals' submitting to a DHR inspection, and since DHR inspection reports on hospitals not submitting JCAHO reports are routinely disclosed under the Open Records Act, common sense dictates that the JCAHO reports used for licensing be also released. The public has a legitimate interest in the records which make up the DHR's hospital licensing decisions."[16]

Conclusion

The high court's decision to allow disclosure of JCAHO accreditation reports appears to have been made in the interest of improving health care in this state by use of public scrutiny. While the decision may very well lead to changes in the face of the accreditation process throughout the state, these changes may not all be improvements. Hospitals which undergo the JCAHO accreditation process may choose to undergo the DHR inspection rather than elect "deemed status" and submit the JCAHO report for public inspection. This may very well create an economic burden on the state of Georgia as the number (and cost) of the inspections it must perform rises; these increased costs may then be passed on, to hospitals being inspected and, ultimately, to the public.

"The High Court's decision to allow disclosure of JCAHO accreditation reports appears to have been made in the interest of improving health care in this state by use of public scrutiny."

Additionally, the Court's decision does not specifically indicate whether JCAHO reports not submitted to the DHR are subject to the Open Records Act, and neither does it indicate whether such reports held by hospitals are discoverable in malpractice cases or other litigation. However, a majority of hospitals in Georgia have submitted JCAHO reports to the DHR already, so those reports will certainly be scrutinized by plaintiffs' attorneys in medical malpractice cases. Those questions left unresolved will likely be the subject of impending Georgia Supreme Court cases.

Notes

1. O.C.G.A. §31-7-3(b).
2. O.C.G.A. §50-18-70 *et seq.*
3. O.C.G.A. §50-18-70 (b).
4. *See* Rule 290-1-2-.01, Rules and Regulations of the State of Georgia, Official Compilation.
5. The DHR named as defendants 63 accredited Georgia hospitals which objected to disclosure of the accreditation reports and the Georgia Hospital Association, which represented the interests of all non-party accredited hospitals in Georgia.
6. *Georgia Hospital Association et al. v. Ledbetter et al.*, No. S90A1022 (Ga. Supreme Court October 4, 1990).
7. O.C.G.A. §31-7-15 (a).
8. O.C.G.A. §31-7-15 (d).
9. 42 U.S.C. §1395bb (a).
10. *Georgia Hospital Association et al. v. Ledbetter et al.*, No. S90A1022, slip op. at 5 (Ga. Supreme Court October 4, 1990).
11. This test was first established in *Houston v. Rutledge*, 237 Ga. 764, 229 S.E.2d 624 (1976).
12. *Board of Regents v. The Atlanta Journal and The Atlanta Constitution*, 259 Ga. 214, 378 S.E.2d 305 (1989).
13. *Georgia Hospital Association et al. v. Ledbetter et al.*, No. S90A1022, slip op. at 7 (Fletcher, J., dissenting).
14. O.C.G.A. §50-18-72 (a) (2).
15. O.C.G.A. §50-18-70 (b) (Emphasis supplied).
16. *Georgia Hospital Association et al. v. Ledbetter et al.*, No. S90A1022, slip op. at 5-6 (Ga. Supreme Court October 4, 1990).

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> Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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Who Put the "X" in Christmas?

PRACTICALLY every year the question comes up: "Who Put the 'X' in Christmas?" Many decry such an unchristian approach to an otherwise solemn occasion.

Actually, it has been there all the time. "X" used alone, or in combination with other letters, often stands for the word Christ. As The Reverend E. G. Gration, an Episcopal priest explains, "This usage is quite ancient, certainly, as ancient as the word "Christmas" itself. It derives from the early use of the first letter of the word "Christ" in Greek. The Greek letter Chi, written as X. "X" for Christ also ties in with the equally ancient Chi Rho, the equivalent in Greek of "CHR" as a symbol for Christ. Then the symbols "IXS" — Iota Chi Sigma: Ieosous Christos Soter — Jesus Christ Savior!

"Christes Masse" . . . Christ's Mass . . . Christmas. All in all, it isn't so much how you spell it, as how you keep it, that determines how Merry will be The Joyous Season just ahead.

MERRY CHRISTMAS TO ALL!

Submitted by
Richard Bynum Weeks, M.D.
Retired Surgeon
St. Simons Island
Source: Jackson, Mississippi
Clarion Ledger

Of Christmas and Hanukkah

(Editor's Note: Marvin Tark, M.D., is an anesthesiologist. He is of the Jewish faith. Some time ago I asked him to review an article submitted for publication in this Journal. *He told me it was "too Christian." "If so," I said to him, "you should write something for us that is 'Jewish.'" This is his response:)*

MY FAMILY and I like to stroll through the malls during the Christmas season, because the displays are so colorful, the atmosphere so festive, and people so joyful. The feeling of joy and goodwill is quite intoxicating. Last year, in the center of the mall, there was a collection of especially attractive displays. There was a full assortment of beautifully decorated trees, laden with snow, shielding a wide assortment of gaily decorated gifts. An ebullient Santa was surrounded by a host of elves and the eversmiling Mrs. Claus. Rudolph was waiting to take Santa on his yearly journey around the world.

My youngest son looked at the entire display and said, "Dad, I sure wish we were Christian. Christians have all the fun. I don't like being Jewish." I took him to a bench and sat him on my knee. "Have you forgotten about our Jewish holiday, Hanukkah?" I asked. "Our holiday is equally as beautiful. We decorate our house with beautiful decorations. We have a beautiful Menorah (candleholder) that we light each night of the 8-day holiday. We sing songs, eat latkes (potato pancakes), and play dreidel (a top used for gambling). You always win $5 for me playing dreidel. Best of all, you get eight gifts, one for each day of the holiday." A big smile of remembrance came over his face, and he nodded. "Oh, yeah, I forgot about that." Sitting next to us was a pretty young girl dressed in a Yuletide red and white outfit. She had obviously overheard my conversation, because immediately afterwards, I heard her say, "Mom, why do we have to be Christian? I want to be Jewish. Hanukkah is more fun than Christmas."

MARVIN TARK, M.D.

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Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See OOSAGE ANO AOMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and AOVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Oosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE ANO ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and OOSAGE ANO AOMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy – Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PO deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Oosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Oosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See OOSAGE AND AOMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(820)

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VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema relat to previous treatment with an ACE inhibito

A diminished antihypertensive effect towa the end of the dosing interval can occur in some patients.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

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